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June 1957, Vol 3, No. 6

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Missionary Doctor in Africa

Parkland Memorial Hospital

Guest Editorial

Clinico-Pathological Conference

Residents Are the Craziest People!

Current Practice Openings: State by State

Mr. Dare's Self-Surgery Machine

Allergy, Accidental Death and the Law

Washington Report

Licensure for Foreign Graduates

Mediquiz

What's the Doctor's Name?

Journal for the Hospital Staff Officer



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Resident Physician

June 1957, Vol. 3, No. 6

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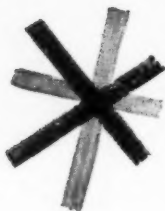


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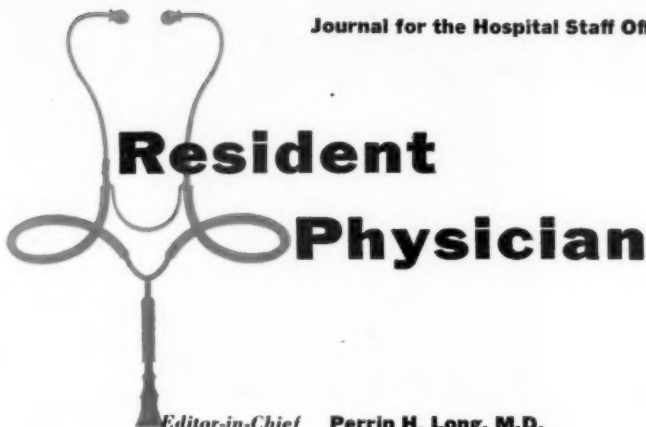
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Resident Physician

Journal for the Hospital Staff Officer



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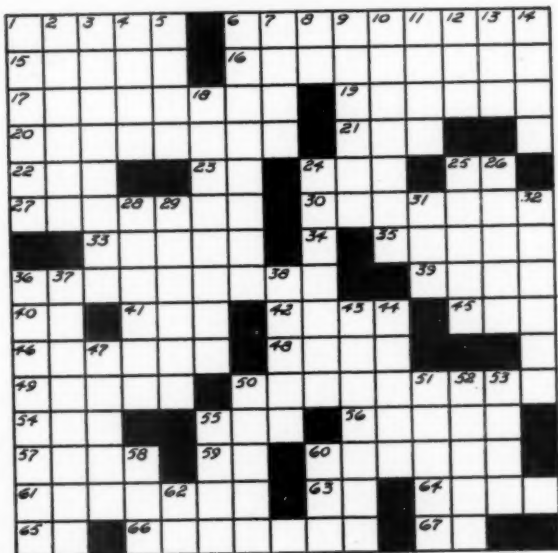
Resident Relaxer



ACROSS

Answer on page 170)

- The Shinbone
Swollen (var.)
Acquire fresh vigor
Physical law, named
for French chemist
(2 wds.)
Fleet-footed huntress
(Greek myth.)
Sugar-coated pill
Irritant in poison ivy
American women's or-
ganization (abbrev.)
Marble (Dial.)
Centimeter (abbrev.)
Posed
Parent
Tincture of monks-
hood
Sum of knowledge of
muscles
Former Persian
dynasty
Singular article
Round-up
Those who withstand
Varnish ingredient
Before noon
Initials, earliest
American Explorer
State
Man's nickname
Behaviorism of
Alcoholic
A sensation, preced-
ing attack of epilepsy
Kind of capsule
Defective
Pitcher
—Pinafore
Whinny
Robe of Office
Three-toed sloth
Word element for
"iron" or "steel"
Emerald Isle
Economic (abbr.)
Depend confidently
Not specified (abbr.)
Ascetic Jewish
Brotherhood
Rare element,
(chem. sym.)



DOWN

1. Injury
2. Suffix, pert. to a
physician
3. Extinct Blue Buck
4. A'mants
5. Hindu Nurse
6. Metazoan Cell
7. Twofold
8. E.bium (Symbol)
9. Noon
10. Apparatus for
oxygenation

11. Former Ruler
12. Old Low German
(abbr.)
13. Society of Automotive
Engineers (abbr.)
14. Water vessel
15. Winks
16. Wreck, colloq.
17. Manner (Lat)
18. Substance which
causes a reaction
19. One who secures
20. Branch of Rhine River
21. Motion picture site
22. Milk product
23. Russian hypnotist
24. Sovereigns
25. Wanders
26. Theology of peace
27. Rowed
28. Scope
29. Ammonia compound
30. Aglow
31. Heron
32. Word element for
bile
33. —C. Anderson
34. Beverage
35. Perceive
36. Since

now "... care of the man
rather than merely his stomach."

**WOLF &
WOLFF**
—
**HUMAN
GASTRIC
FUNCTION**

Milpath

Miltown® + anticholinergic



controls gastrointestinal dysfunction

because it cares for the man

At the cerebral level

the tranquilizer *Miltown* in "Milpath" controls the psychogenic element in G. I. disturbances. (*Miltown* does not produce barbiturate loginess or hangover.)

as well as his 'stomach'

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(3-diethylamino-1-cyclohexyl-
1-phenyl-1-propanol-ethiodide)
U. S. Patent 2,698,325

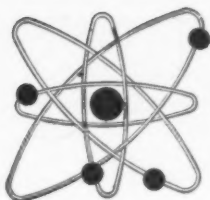
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Resident Physician

Viewbox Diagnosis

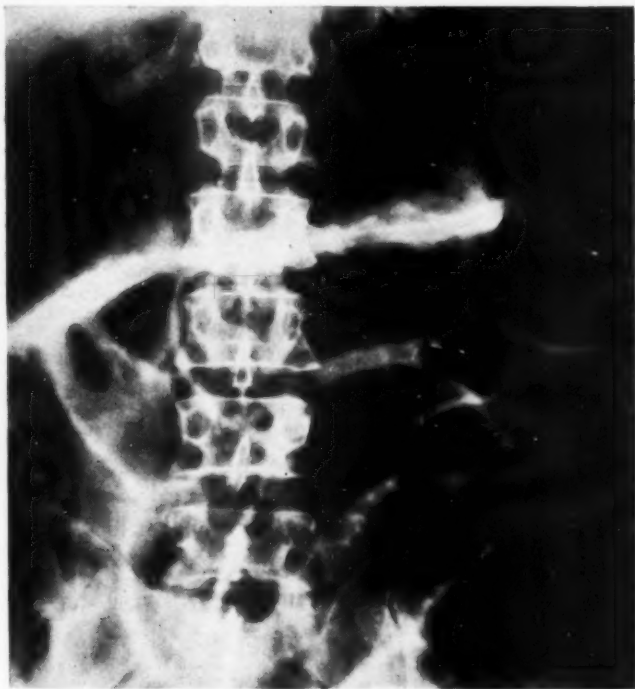
Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center



Which Is Your Diagnosis?

1. Mechanical obstruction
2. Ileus
3. Normal

(Answer on page 170)





CHECK

INFLAMMATION

With No Danger Of¹

- Delay in wound healing
- Changes in peripheral blood picture
- Hemorrhage, hematoma or petechiae
- Granulomas at injection site
- Chills, cyanosis or allergic reaction
- Aggravation of infection

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1. Miller, J. M.; Surmonte, J. A.; Ginsberg, M., and Ablondi, F. B.: *Postgraduate Medicine* 20:260 (Sept.) 1956.



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Letters to the Editor



Unsigned letters will neither be published nor read. However, at your request your name will be withheld.

How About Interns . . . ?

How can interns arrange to get **RESIDENT PHYSICIAN** each month . . . ?

I'm an intern. You don't send me your journal. I read it anyway. But my conscience is bothering me because I have to steal a copy every month from one of the residents. Make me an honest man. Please put my name on your circulation list. . . .

What about interns? Why can't we get **RESIDENT PHYSICIAN** mailed to us? . . .

I understand you do not mail **RESIDENT PHYSICIAN** to interns. Why not? If it is because you think we aren't interested in your publication, I can assure you that this is not the case—at least in my hospital. Please reconsider your policy if at all possible. Those of us who are able to scrounge copies find each issue of real value and interest. . . .

• *These remarks, taken from our file "Intern Readers," are typical of hundreds we've received in letters*

from interns during the past two years. All were answered by letter. "We are," we wrote, "considering adding interns but at the present time we are concentrating our circulation among residents. Soon we hope to be able to add all interns."

*In addition to letters from interns, our own surveys of readership have shown that more than 50% of all interns read copies of **RP** "borrowed" from residents. Recently, armed with these facts, we approached a number of our advertisers. Would they be willing to pay an increased page rate (reflecting only the added mailing, printing, paper and circulation costs) to reach interns through an expanded **RESIDENT PHYSICIAN** circulation? Obviously aware of the interns' important role in hospital treatment and prescription-writing, these companies indicated they would welcome an opportunity to bring their products and services to the attention of intern readers of **RP**.*

In effect, they told us: "Go ahead. We're with you."

That's the story . . . and in a few

—Concluded on page 32

CLINICAL COLLOQUY

My patients complain that the effect of the pain tablet I prescribe often wears off in less than 3 hours.

Why not try the new codeine derivative that's combined with APC for faster, longer-lasting pain relief?

You mean something that doesn't require repeat dosage so often?

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How about side effects?

No problem. For example, the incidence of constipation is rare with Percodan.^{}*

Sounds worth trying—what's the average adult dose?

One tablet every 6 hours. That's all.

Where can I get literature on Percodan?

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^{*}U.S. Pat. 2,628,185. PERCODAN contains salts of dihydrohydroxycodone and homatropine, plus APC. May be habit-forming. Available through all pharmacies.

—Concluded from page 24

months, ALL INTERNS WILL BE ADDED TO OUR CIRCULATION.

Our new circulation will also include all chiefs of the various medical and surgical services as well as full-time professors and the directors of intern and resident training. In an enthusiastic response to a special letter mailed to a representative group, selected at random from among teaching hospitals throughout the nation, the chiefs and training directors indicated overwhelming approval of the value of RP and expressed their desire to have copies mailed to them each month.

Naturally, as with our resident circulation, we want to make sure we reach every intern in the U.S. with every issue. So, if you are an

intern, and to be certain you will receive the first and subsequent issues mailed to interns, we ask you now to fill in the coupon, tear it out, paste it on a two-cent postcard and send it to us right away.

Ship's Doctor

A most thorough report was yours on ship's surgeons by Dr. Dvorine. I've always wondered about this phase of practice. Now I have some answers and have gone ahead with a series of applications. I'll let you know how I make out—and perhaps, if you're interested, give you a story of my own experience as a sea-going physician. W. R. Brooks
Atlanta, Ga.

• We are interested. Thank you for your comments.

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Specialty _____ My chief is Dr. _____

I expect to enter practice _____
month _____ year _____

The editors ask residents now receiving copies of RP to pass this coupon along to an intern on your service.

Perrin H. Long, M.D.



Editor's Page

Drugs, Devices, and Hospital Equipment: Who Starts the Ball Rolling?

Not long ago, a resident asked me "Who recommends new drugs and equipment for the Kings County Hospital Center?" This question made me think. I of course knew that frequently, after reading about a new drug, I had inquired as to its availability and price from the company's hospital representative, and subsequently, I had asked the chief pharmacist to order a supply for the hospital pharmacy.

From time to time, I have also recommended the acquisition of certain items of equipment.

However, as I thought more about the resident's question, I realized that quite often it is one of my interns or residents who first asks me about this drug or that piece of equipment. I wondered how often this happened in other hospitals.

Early this past May, while attending the meeting of the Association of American Physicians in Atlantic City, I spoke of this point to a number of my colleagues.

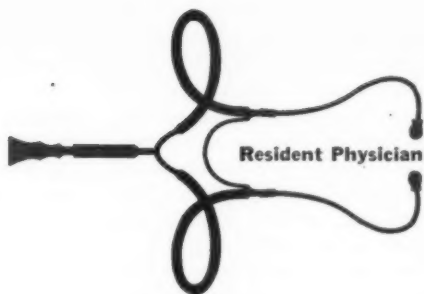
Their initial reaction to the question "Who recom-

mends . . . ?" was that they themselves or their colleagues generally suggested the introduction of new therapeutic agents or the purchase of devices or equipment in their hospitals. But, after some consideration, it was agreed that in their hospitals (all were university hospitals), new drugs were introduced in three major ways. First, because a staff member of the hospital was interested in the field covered by the new drug and hence was asked to be one of its responsible laboratory and clinical investigators by the company interested in the new agent. Secondly, because a senior member of the staff had read or heard about the new drug. Thirdly, because a member of the house staff had read or heard about it and wanted to do work with the new product.

However, when we discussed what happened relative to this question in non-teaching voluntary, and governmental hospitals, my colleagues familiar with what went on in these institutions, brought out the point that the house staff in non-teaching hospitals very frequently requested new therapeutic agents and diagnostic or medical equipment which they had read or heard about, for use in their wards and laboratories.

To my mind, this points up a situation which should be of interest to all members of the house staff of any hospital, namely, that you are important factors in the introduction of new drugs and medical equipment in this country. This means, that you should be on the ball relative to what you hear at medical meetings or read concerning new drugs or new diagnostic procedures, because it may be *you* who sparks the introduction of that new drug or test which may make a whale of a lot of difference to the well being of one of your patients.

Perin H. Long.



Missionary Doctor In Africa

An account of service to neglected peoples by a missionary surgeon. His dedication, devotion and love of God and man, typifies the work of hundreds of American physicians who have elevated their profession in the attainment of its highest objectives.

Donal C. Edwards, M.D.

THERE is a tremendous satisfaction and feeling of accomplishment having served as a medical missionary in a foreign land. I can state this for a certainty. But with equal certainty I can assure you that there is a continuing demand for physicians to join the various religious missions in their Christian service to pagan peoples throughout the world.

The missionary doctor is needed both by his fellow missionaries and the natives among whom he lives and works.

The value of his medical contribution, of course, materially enhances his opportunity and importance in furthering the spiritual work of the missions.

Opportunity

The missionary doctor is often a leader in the development of new missionary activities and in opening new fields of religious opportunity. He is a member of a team dedicated to bringing the Gospel into the hearts and lives of more of the peoples of the world.

Less than a year ago, I completed four years of missionary medical service in Nigeria. As you read this, I will be getting ready to go back, after having spent a year's furlough in the U. S. in a surgical residency.

As a doctor equipped with most of the tools, drugs and therapeutic information available to members of our profession, I was able to practice the art and science of medicine in such a way as to give satisfaction, with God's help, and to enjoy a continuous source of opportunities for education, experience and research.

How does one get started in this work?

I don't believe there is any pat answer to this question which would fit all medical missionaries. It is something like the question repeatedly asked of all physicians: "Why did you decide to become a doctor?"

There are many factors influencing each individual. All I know for certain is that my own interest in medical missions preceded my entering medical school. This interest stemmed from a combination of two

desires: to serve the Lord and to become a doctor.

After graduation from medical school in 1947, I took an internship and a surgical residency. Then came a final step of medical preparation. To gain a wider acquaintance with the needs and problems of tropical regions, my wife and I packed our belongings and headed for the Panama Canal Zone.

While practicing for a year in Panama, I kept in touch with the Sudan Interior Mission in New York City. It was my intention to serve in Nigeria, West Africa. The S. I. M. was active in this area.

Still interested in Africa, my wife and I applied to the S. I. M. upon our return to the United States. For the next five weeks, along with other young couples who wished to become missionaries, we were instructed in the work to be done and advised of the problems we could expect to meet in the field.

During this period we were introduced to missionaries and in our talks with them, satisfied ourselves as to our compatibility and suitability for the mission work we had chosen. Previous to the five-week period, my wife and I had submitted a thesis setting forth our beliefs concerning the Christian religion (a statement of faith) which was studied by S. I. M. officials to aid in their determination of our spiritual qualifications as potential missionaries.

Finally, our health having been

carefully checked, the day arrived when the Council of the Mission met to approve or disapprove each candidate.

We were overjoyed when all in our group were accepted, an unusual event. Some in our group were nurses, some teachers, others ministers. I happened to be the only physician.

Church support

The next step for the S. I. M. missionary is to seek the support of an individual church which will agree to sponsor the missionary and his family. (Various missions handle this important question of support in different ways.)

My wife and I and our young children returned to our church home in Boston, there receiving a promise of support from the mis-

sion-active Park Street Church. At that time, the Park Street Church had 125 missionaries in various areas.

Church support, a nominal amount paid yearly, becomes the sole income for the missionary. It provides his travel expenses to and from the field, helps him with medical expenses for himself and his family if such a need arises.

Having obtained support, our departure from Nigeria was delayed by the doctor draft. However, as an ordained medical missionary, I later became exempt from military service and was able to proceed to Nigeria with my wife and two children.

The problem of obtaining and packing clothing and equipment for four people to last four years is not the kind of a problem which

About The Author

Born and raised in Minnesota, Dr. Edwards entered Harvard College in 1941 and the medical school in 1944. After graduating from Harvard Med in 1947, he took a rotating internship and a year's surgical residency at the Springfield Hospital, Springfield, Mass. After another year as a physician in the Panama Canal Zone, the author took a temporary position as a staff physician at the University of Massachusetts while awaiting permission of the draft board to embark on his missionary work. Sailing in 1951 for Nigeria, West Africa, with his wife and two small children, he completed four years and eight months missionary service including three years at the Bauchi Leprosarium and one year at Kaltungo Hospital before returning to the U.S. with his wife and four children last year. His furlough is being spent as a resident in surgery at the Broaddus Hospital, Philippi, West Virginia. He and his family expect to return to Nigeria in September.

Sudan Interior Mission

Since the Sudan Interior Mission was founded in 1893 by Rowland V. Bingham, it has grown to international scope with headquarters in New York, Toronto, Liverpool — and in South Africa, Australia, and New Zealand. S.I.M. has more than 1200 missionaries serving in eight African countries: Liberia, Nigeria, French West Africa (Niger Colony and Dahomey), Sudan, Ethiopia, Somalia (United Nations trusteeship), Eritrea, and in Aden, Arabia. Missionaries come from Canada, United States, Iceland, Scotland, England, Germany, Switzerland, South Africa, New Zealand, Australia — from nearly all the evangelical denominations—and are supported entirely by gifts from local churches and individuals.

Other missions similar to the S.I.M. include the China Inland Mission, the Africa Inland Mission, South African General Mission, North Africa Mission, West Indies Mission, Latin American Mission, Central American Mission, the Evangelical Alliance Mission, Far Eastern Gospel Mission, and others working in nearly every country in the world.

occurs with any kind of regularity to anyone. This "advance planning, plus"—is, in itself, an experience. Yet, somehow we made it and all was ready. We were put aboard a freighter bound for Africa.

Unknown dangers

For myself, the thrill of setting out in a new work to a continent that had long occupied an important place in my thoughts, far overshadowed any hesitation or doubt—or worry as to possible dangers.

For my wife, however, even though the time we spent together in the Canal Zone helped remove many uncertainties and fear of the tropics, the unknown dangers of strange diseases and animals was for her a strongly disturbing factor and was partly due to her natural concern for our children.

Yet, her Faith and trust in the Lord enabled her to face this problem. And by the time we boarded our ship, she was looking forward with me to our first glimpse of Africa.

Our ocean trip was both tranquil and to me, surprisingly quick. We passed between two hurricanes and enjoyed calm water all the way. Barely 17 days from New York, we steamed into the harbor at Lagos, Nigeria—having made but one brief stop at Freetown, Sierra Leone.

Hectic days

The first few days in Lagos were hectic. Clearing our goods through



Photo taken last year at Kaltungo Hospital just prior to the author's return to the U.S. from Africa. Dr. Edwards holds son Richard, 2, who was born in Nigeria as was month-old Greg, held by daughter Marcia, 7. Mrs. Edwards is seated next to oldest child, Stephen, who is 8 years old.

customs, converting traveler's checks to British pounds, shilling and pence (and trying to memorize the value of each of the strange coins and bills), and getting through passport checks seemed an endless process. Following this came the necessary consular visits, securing driver's licenses and a host of other details all conducted in a strange city in southern Nigeria which was melting under blistering heat punctuated at sudden though brief intervals by torrential downpours.

One point was in our favor. We had no language problem; since Nigeria is administered by Great Britain, English is the main language of the southern part of the country. Our newness in this land was also eased considerably by the help of our mission representative who was there to guide us through the red tape.

Nigeria

Nigeria is the largest British colonial territory. To compare it

with something well-known for its bigness, Nigeria is nearly one-third larger than Texas. Located on the African Gold Coast, Nigeria is tucked into the corner of the prominent, right angle indentation of the western coast line of Africa. Nigeria's own coast line borders on the Gulf of Guinea in the South Atlantic Ocean. Stretching up from the coast 600 miles north to French West Africa, the area contains valuable tin and lead mines and exports such products as palm oil and kernels, cotton lint, cocoa, hides and skins, and rubber.

Its population has been estimated at 32 million (about four times that of Texas). The tin and lead mines have promoted the rapid development of an extensive railroad system. The Suez Canal located in

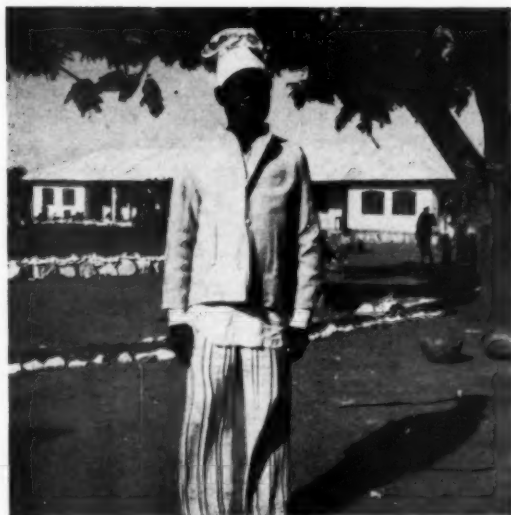
the northeastern corner of Africa is approximately 1,000 miles northeast across Africa from Nigeria.

In Lagos, we were at once struck by the many strangenesses and contrasts encountered: from the modern stores and buildings of British colonial style to the new and old homes and buildings of the nationals; the careful Western-style dress of some natives, to the pajama-like styles of the southern peoples, or the near nude 'undress' of the less advanced. The hurrying crowds, thronging cars, taxis and buses had a familiarity, yet a complete strangeness—for the crowds had dark skins, the motor vehicles were of strange styles and driven on the left hand side of the road. And as we went farther out of the city, we met more and more primitive conditions and

Author's house at Leprosarium is typical of the S.I.M. missionary home.



In the foreground is the proud, capable African "dispenser" whose dress befits his position of eminence among the natives. In the background can be seen the Bauchi Leprosarium Dispensary.



people. The veneer was very thin indeed.

Bauchi Plateau

Nigeria lies just above the equator and extends northward to the edges of the Sahara desert. In the coastal lands are the dense jungles of tropical Africa. But as one travels northward, gradually the jungle thins out giving place to Savannah lands, with tall Sudan grass, a few trees, and brush. This in turn gradually becomes sandy, bushy country with palms, camels, and the sub-Sahara heat and sandstorms.

Two huge rivers, one of these the mighty Niger, course down across Nigeria from both upper corners, meeting in the central south to di-

vide the country, like a huge 'Y', into three geographical and political divisions. Other large rivers are mainly the products of the seasons—rising with the rains, falling and disappearing (as do the small streams) in the dry season.

Above the center of the 'Y' lies the famous, rocky, practically barren, Bauchi Plateau, a large area well over 3,000 feet in elevation. World-important tin and gypsum mining has been carried on here since the earliest development of the interior of Nigeria.

Here, in the relative coolness of the Plateau, many missions have their field headquarters, including the S. I. M. And here is located

our Missionary Nursing Home, Vacation Rest Camp, and school for missionary children.

Train trip

Within a few days we were ready to leave Lagos and take the train 600 miles into the interior, a two-day trip. Preparing for the long journey in our train compartment, we bought oranges and bananas three for a penny.

The train was slow, the route tortuous, the stops frequent and long. Our tickets were checked repeatedly by the conductor, distinguished from the ordinary Africans by his woolen overcoat and heavy, fur-lined earflap helmet—this in sweltering, tropical heat!

For us, the discomforts of the

trip were all but forgotten in our excitement over seeing this new country and the noisy, busy African people encountered at every village stop.

At last came our stop. We had arrived at what was to be our home for the next six months while we studied *Hausa*, the language of the northern territories.

The train lurched to a halt and in a drenching downpour we and our bags were ushered off the train.

There was not a white face in sight. Unlike Lagos, here there was no English language; here there were no mission people to guide us. We felt utterly alone.

Fearful lest our baggage would be permanently carried off, we clung to bags and children, and dashed

Outpatient department. Patients wait for medicine at missionary station dispensary in Katanga. Their need for medical attention is "indescribable."



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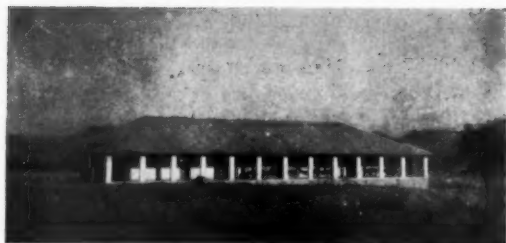
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Surgical building of
Kaltungo Hospital.



for the shelter of the station roof. Just at that moment, a 'carryall' drove up and out popped three missionaries. One of our greeters was yellow with Atabrine. He proved to be one of our new doctors just finishing language school and getting ready to go up to French West Africa to build a hospital. He and his two companions were a welcome sight.

Mission station

Quickly loading us into their vehicle, they drove us the mile back to the mission station where we met thirty-five young missionaries in various stages of learning the Hausa language. Soon we were installed in our mud-walled, grass-roofed house and the next day began our daily studies with the missionary teacher and *Hausa Malams* (semi-educated, Hausa-speaking men who were our tutors).

Here began a great experience and education in becoming acquainted with the African people, their ways and their customs. We

were introduced to the system of manual assistance each missionary is afforded. Both a blessing and bug-bear, the assistance came from "boys," young men employed in the house to carry water, prepare beds, cook, sweep floors, do laundry, look after the children, and who perform numerous other large and small duties freeing the missionary for his work.

Hausa

The Hausa language, one of the easier African languages, is also one of the major languages of West and North Africa and has been used in trade and commerce for centuries. Written in arabic type characters, it was subsequently reformed by missionaries into a phonetic alphabet script. The Bible is translated into Hausa. Used by hundreds of missionaries for years, Hausa is essential for work among the northern Nigerians who, though they also share some 300 other tongues, speak it well or poorly. It becomes for the missionary the vehicle of his com-

munication with the people.

The language has many interesting features, being a tonal language, and it helped us to understand our own Bibles better as we gradually learned the customs of the people, many of which were exactly the same as in Biblical times.

Mission work

Having been introduced to the Hausa language, and now able to speak and understand well enough to get along, we were sent another 600 miles northeast to Bauchi, there to build a leprosarium.

In three years we built our homes, huts for 400 patients, a hospital, administration building, church, storehouse, schools, crafts building, and three buildings in which to house 100 children.

In addition we helped to organize and supervise leprosy clinics and segregation villages at eighteen mission stations up to three hundred miles away. Supplementing our lep-

rosy work, we carried on an active surgical practice and supervised general medical dispensaries at these eighteen stations plus three others.

In our last year we were transferred yet farther east, to build (or start) a general hospital. This we did while carrying on the above-mentioned work. We were able to accomplish these many duties only with the aid of hard working missionary nurses, and such aids for travel as motorcycle, car, and airplane. My car travel alone took me over 50,000 miles in 56 months.

When we left Nigeria after four years and eight months (we stayed eight months longer than the normal four-year term of our missionaries in order to get the hospital at Kaltungo underway before we left) we had a surgical building with operating room and ward space for 24 mat beds.

When we return to the Kaltungo Hospital after our year's furlough,



Sudan Interior Mission school for missionary children.

we hope to enlarge it to include several wards, and provide increased services and equipment such as x-ray.

As Dr. Albert Schweitzer pointed out in an article in the *Journal of the American Medical Association*, December 1955, surgery is one of the most useful and most needed work among the Africans. Afflictions remediable by surgery are the most incapacitating; most of the medical diseases can be handled adequately by nurses, with supervisory help from the doctor.

This need for surgery, plus my own interest primarily in the surgical specialties, prompted my continuation in a surgical residency during my present furlough year.

Advanced disease

The most impressive thing about the surgical problems in the African is the long standing and advanced nature of their diseases. Hernias and hydrocoeles are almost all massive and difficult. Infections are invariably advanced, usually with large ulcers and osteomyelitis. Many times one is faced with salvaging life that has been badly threatened by witchcraft practices and unbelievable maltreatment. In some places fear of the white doctor has to be overcome. Fortunately, we did not encounter this often, finding most of our patients ready to do anything needed and undergo any surgery recommended. Without hesitation, they put themselves completely

and trustingly in our hands.

Our work is basically evangelistic (bringing the message of the Gospel). Our medical work is a means to this end—to reach the hearts of the people. It also becomes a work of compassion because of the indescribable need. The missionary doctor is in the position of being the only one available to help.

Our mission has many growing, healthy churches among former pagan and cannibal peoples and medical work has played and is playing a leading part in this effort.

The Christians are on the whole healthier, happier, wealthier, more generous, and more mature than their non-Christian compatriots. They are a delight to work with, and willingly volunteer in hospitals and dispensaries for ancillary medical services; many of them become nurses, midwives, technicians, dispensers, and so forth.

My surgical assistant was an English-speaking African trained in lab technology and further trained by me to assist at surgical operations.

In Nigeria and French West Africa, the Sudan Interior Mission has seven Leprosaria, two general hospitals, a renowned eye hospital, a hospital for missionaries (of our own and sister missions), numerous dispensaries, leprosy clinics and segregation villages, and of course great numbers of schools, churches, Bible schools, orphanages, printing presses, publications, and so forth.

There are more than 600 mis-

sionaries in these two countries from the S.I.M. alone, and over 1200 on all our African fields. In this number, we have approximately 16 doctors in the West African fields, and a large central pharmacy for the provision of drugs and supplies. Once a year these doctors meet together for a three- or four-day conference on leprosy and medical problems, and to present papers on medical subjects. Doctors of other missions are invited to participate and many do so.

Books and journals reach us from the United States and England and we are able to keep fairly well abreast of medical advances. We are hampered to some extent by lack of equipment and facilities; as these are provided through funds from friends and churches at home, we enlarge and extend our medical services.

Our own personal lives are made easier by adequate homes built of mud brick, with aluminum pan roofs, large windows, screens, cement floors. We use kerosene refrigerators, gasoline washing machines. Radios and lighting are operated by electricity provided by gasoline or diesel generators.

The Sudan Interior Mission also has a few small airplanes with experienced pilots for emergencies or long trips. Certain foods and clothing are becoming more readily available within the country now than formerly.

Mail service brings us letters and

parcels from home. Our recreation is varied. I enjoy hunting and thereby keep a ready supply of wild fowl, antelope, and small game on the table. Bigger hunts take us after hippopotamus or the large antelope. I have also managed to shoot leopard, hyena, and wild pig.

The problem of heat is met by light clothing, rest during the noon heat, and a gradual acclimatization which works wonders. We are bothered occasionally by snakes, constantly by insect pests, and take continuing precautions against malaria and amoebic and bacillary dysentery. Antimalarial drugs are not 100 percent effective; by judicious drug combinations, most missionaries remain free of clinical malaria most of the time.

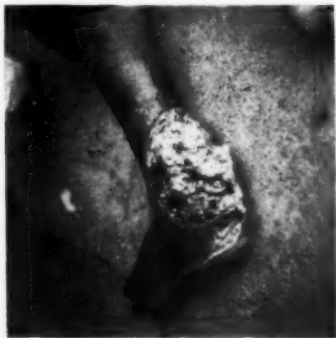
School children

Our term in Nigeria was blessed with the addition of two boys to the family. They were born in our missionary nursing hospital under the best of conditions. Our second baby was born with malaria, but was quickly treated. Our two older children, a boy and a girl, became of school age on the field and attended the S.I.M. school for missionary children on the cool Bauchi Plateau. Beginning with a handful of pupils a few years ago, the school has increased in size to keep pace with our growing mission and increasing numbers of children.

My children had ninety classmates; there are over three hundred



Author's snapshots show some of the problems seen by the missionary doctor in Nigeria. Above (left) is woman with 'lepro reaction' nodules on her back. Boy, 12, exhibits lepromatous leprosy. left is frequent aftermath of a witch doctor's treatment. Child injured arm in a fall. Below is woman (discussed in story) with massive tumors who died while in the hospital. Other photo shows typical advanced ulcers of child's leg.



pre-school children in our West African fields who will be ready to enter school within the next three to four years. Nine months are spent at school, and the three "summer" months at home on the mission station.

Our children are away from us most of the time but they are nearby where we are able to visit them. Summers are times of grand reunion. The children renew acquaintance with their toys, the station, and their African friends. But before summer is over, they are anxious to get back to school with their chums, fine teachers, and the many school activities and sports. The children's real enjoyment of school is a help to the parents when it comes time to separate from them.

Spiritual, medical

As you can well imagine, the combination of spiritual and medical work is most satisfying and interesting, reaching out as it does to the two most important human needs—spiritual and physical.

The worth of both phases of our work is pointed out to us over and over again in the profuse gratitude of the healed patient, and the serene joy of the converted person facing ordeal and even death.

This latter experience can be illustrated by the case of a woman brought to us with a huge ovarian tumor. Too run-down for immediate surgery, she spent two months with

us as we attempted to build up her health prior to surgery.

At the same time we had an opportunity to tell her repeatedly of the Gospel of Salvation in Christ Jesus, which she accepted with her heart (this, in spite of the fact that she belonged to one of the more advanced religions of Africa).

Surgery proved her tumor to be malignant and advanced; she died five days later. As her life left her, she expressed her joy in her new found faith and her certainty that she was going to be with Jesus.

After her death, her husband helped us give her a Christian burial; he told us with obvious conviction that he had *never* seen anyone with such peace and joy as she had, even in the face of death.

Such experiences are not rare and are more than compensation for being far from home, among strangers, poor in material things; these experiences afford us positive evidence of the value of our medical missionary work.

As you know, opportunities for Christian medical service are not limited to foreign countries. Mission work using doctors is carried on in many parts of this country, including work among American Indians, backward and rural mountain districts, and isolated northern regions. Also, Government positions are open in which the Christian doctor can find opportunities for Christian service both within the position and

during off duty hours (as we did in the Canal Zone).

Foreign mission opportunities are many, both within the Western Hemisphere, and in the Africo-Asian countries. Government medical services in the majority of these countries are either non-existent, or too limited to meet the tremendous needs of the people.

Many different missions of various denominations are working in these countries. Most have medical services in need of doctors, nurses and dentists.

The S.I.M. needs doctors, both specialists and general practitioners, in seven African countries. Many missions will accept a doctor for short periods of service of one or two years to relieve their own doctors on furlough who may not have replacements. Some doctors go for a single term of from three to five years.

The doctor who wants to make

medical missions his lifetime career will find himself in a joyful, useful work which will repay him many times over in satisfaction and Christian experience and fellowship while permitting him to carry on his own specialty, completely and with no competition.

Of great help to the medical missionary is the new "Brother-Physician" plan of the Christian Medical Society. In this plan, each doctor on the field has a brother physician at home who corresponds with him, helps with information, books, drugs, and lines up educational opportunities for the furloughing doctor. Working together, the Christian missionary doctor and his brother physician extend a long, strong hand of skill and love to the earth's neglected peoples.

To be a part of this aid, to serve and honor Him on this earth, is the motivation, inspiration and strength of the missionary physician.

Parkland Memorial Hospital

Drawing on an extensive pool of teaching patients both within its own walls and in affiliation with other area hospitals, this newly constructed, university-affiliated county hospital offers approved residencies in 13 specialties.



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**One of a series
on leading resident centers**

Parkland Memorial Hospital, operated by the Dallas County (Texas) Hospital District, is the principal teaching hospital of the University of Texas Southwestern Medical School. Adjacent to the medical school and about three miles from downtown Dallas, Parkland houses more than 600 beds and bassinets in a modern, \$10 million building completed in 1954.

Early clinic

Prior to 1878, Dallas had no hospital within several hundred miles. In that year, a physician was employed whose job was to "inspect the jail and give medical assistance to prisoners and paupers." His "hospital" was a crude, lean-to structure owned by the city and fitted out as a clinic.

Seven years later, in 1885, 25 beds were trundled into an old school house. This enlarged facility became, after some remodeling, the first Dallas hospital. Operations performed in the wards by uncertain lamplight, and a police patrol wagon which served as a part-time ambulance were among the difficulties under which this first Dallas hospital cared for the city's indigent sick.

From these beginnings the Dallas County Hospital District has expanded into its present form, a modern and integrated medical care and research center whose nucleus is the Parkland Memorial Hospital. Other recent construction includes a staff residence, and an outpatient clinic building now nearing completion. Each of the latter units cost in excess of \$1 million.

Nearby, the former Parkland facilities have been converted to Woodlawn Hospital which houses tuberculosis, psychiatric and geriatric patients. Resident programs in Woodlawn Hospital are under the direct supervision of the chiefs of service of Parkland Memorial. The Dallas County Hospital District offers a broad program of service to the community including facilities for the care of contagious diseases, tuberculosis and psychiatric patients. Parkland, a general acute hospital, is operated under a hospital board of managers. It is fully accredited by the American College of Surgeons and the Council of Medical Education and Hospitals of the American Medical Association for internships as well as by the respective specialty boards for residencies in medicine, obstetrics and

View of the operating room during a "dry heart" operation shows the coordination required of various members of the operating team.



Parkland Memorial Hospital — The primary teaching hospital of The University of Texas Southwestern Medical School.

gynecology, pathology, orthopedics, surgery, radiology, pediatrics, psychiatry, urology, anesthesiology, ophthalmology, neurology and pulmonary diseases.

Dallas, a growing county of 700,000 population, is the leading medical center in the Southwest. And Parkland and Woodland Hospitals, as the primary teaching hospitals of The University of Texas Southwestern Medical School, are not only equipped with the high standard facilities of new and modern hospitals but also with many research facilities.

The chiefs of service in the medical school are the chiefs of the corresponding services in the hospitals. The result is a well organized, closely integrated program assuring residents a maximum amount of instruction time by qualified leaders in their respective fields. The pro-

gram is further enhanced by the fact that more than 85% of the hospital patients are charity; thus, residents are afforded an opportunity, under adequate supervision, to participate actively in planning the care of the patients.

Active

The total number of admissions over the past several years has averaged in excess of 16,000 a year and is continually expanding with the increased facilities provided by Parkland Memorial.

Parkland has a large and active outpatient department. Clinic visits for the past several years have averaged in excess of 90,000 a year. Parkland Memorial also maintains an active emergency service which for the past several years has averaged some 60,000 patients a year.

The hospital maintains a well

equipped and comfortable library in which all of the important current journals are available and in which back issues are maintained. The total number of books and journals exceeds 2000. The facilities of the large medical library of The University are available to residents.

Medical service

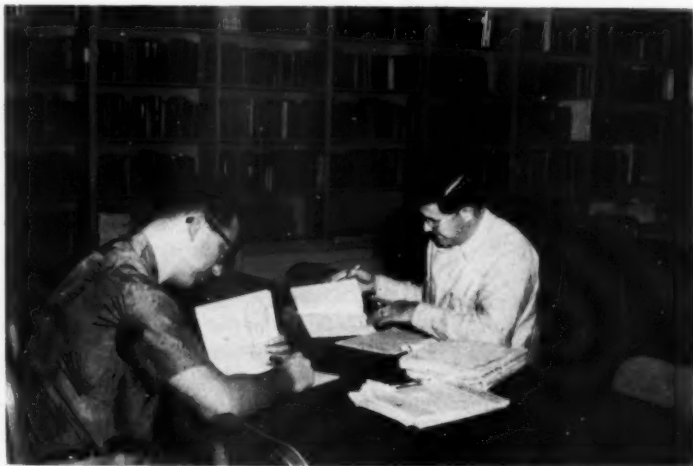
Parkland's residency training program in medicine is fully approved for three years of training. The medical service consists of four ward services, the emergency service and the outpatient division.

During the first year of training, interns rotate through the medical

wards and the emergency room. One or two rotating interns and one straight medicine intern are assigned to each ward, thereby obviating excessive amounts of routine work and affording ample time for patient care, reading and study.

Ward rounds are conducted daily by a member of the full-time staff alternating with a member of the attending staff. In this manner, alternative points of view are presented and intensive use of clinical material for teaching purposes is facilitated. In addition, various sessions are regularly scheduled in specialized disciplines by members of the full-time staff where particu-

The hospital library has seating accommodations for 120 persons. This library is in addition to the medical school library in the adjacent University of Texas Southwestern Medical School.



lar clinical problems are explored in great detail. By these means, the intern is afforded training in the broad area of clinical medicine as well as in the more intense diagnostic and therapeutic approach of the specialized disciplines.

Assistant resident

The assistant resident is responsible, under the guidance of the full-time staff and attending physicians, for the overall management of the ward. He participates in the outpatient clinics, thereby enabling him to follow the patients after discharge from the hospital in an uninterrupted fashion.

The program during the second and third years of residency affords intensive training in the various medical subspecialties, namely, cardiology, pulmonary disease, hematology, infectious diseases and metabolism. The assistant resident rotates through each of these medical specialties consulting on all patients pertinent to his division and working in the laboratories and clinics of the respective divisions. He learns the specialized techniques and procedures of the various branches of medicine.

This program may be extended for a third year residency with opportunity for research, or for more intensive clinical training in any one of the specialties, should he so desire. The entire program is designed to offer training in a wide spectrum of medical illnesses, and

in addition, gives the assistant resident a working command of the specialized techniques and procedures in the various branches of medicine.

Psychiatry

The residency training program in psychiatry is approved for three years by the American Board of Psychiatry and Neurology. In almost all cases, residents hold fellowships in psychiatry at the medical school. The program is dynamically oriented, and during all three years a major emphasis is placed on the resident's individual supervision by qualified psychoanalysts and experienced psychotherapists.

The first year resident is assigned to the in-patient service. Second and third year residents are assigned to the outpatient clinic and to a consultation service in the general hospital, but they may elect work in child psychiatry, ward administration, psychosomatic medicine, neurology or research. Formal instruction is provided in the several basic sciences of neurology and psychiatry.

Residents are expected to fulfill minor teaching assignments in their third year. Fourth and fifth years of experience in the academic setting are generally encouraged, and to this end the medical school has provided several instructorships in the department of psychiatry. In these years, work under supervision may be continued at the discretion of the postgraduate committee.

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Treadmill in the cardio - pulmonary laboratory. One of the many areas in which the latest scientific equipment is used for both research and service.

Pediatric training

An approved program for straight pediatric interns and first and second year residents in pediatrics, utilizing the large and varied clinical, in-patient and out-patient material of both Parkland Memorial Hospital and the Children's Medical Center, offers training adequate for a well rounded career in specialty practice at a superior level.

The program is planned and carried out by the department of pediatrics at the University of Texas

Southwestern Medical School, the staff of the two hospitals and qualified members of related specialties, using all of the clinical and research facilities of all three institutions.

More than 80% of the patients are medically indigent and are under the immediate personal management of the residents, although the faculty and attending staff, constantly available for consultation, systematically guide and review the house officers' work.

The pediatric service at Parkland

Memorial Hospital consists of 48 beds for general pediatrics, an isolation unit for common communicable diseases, and the newborn and pre-mature nurseries. The Children's Medical Center has 108 beds for general pediatrics and 25 beds for children with tuberculosis, it also has the outpatient and special clinics.

Each year about 4,000 newborns, 400 prematures, 5,000 infants and children with a wide variety of acute illnesses, and 50,000 outpatients are examined and treated by the house staff. The material is well distributed over the spectrum of situations encountered in pediatric practice; the frequent, everyday problems as well as complex and serious illnesses, acute emergencies, pre-and post-operative care and a large variety of congenital

heart disease.

Practical experience with patients, under competent guidance, is supplemented by a comprehensive co-ordinated program of ward rounds, teaching conferences and seminars so planned as to combine the advantages of continuity of supervision by the full-time faculty with the practical experience and point of view of board certified pediatricians actively practicing pediatrics or one of its subspecialties.

All have the philosophy that house officer training is an important phase of medical education. The house staff has the opportunity to learn by teaching, because each officer shares in the teaching of medical students, student nurses, and rotating interns assigned to the pediatric service.



Cineangiocardio-graph which takes high speed movies of fluoroscopy of the heart at right angles.

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Obstetrics, gynecology

The department of obstetrics and gynecology has an unusually large volume of clinic material which affords an excellent opportunity for extensive experience at both the resident and intern level. Resident and Intern programs are supervised by a full-time staff with the assistance of an active part-time staff. Residencies are fully approved and are competitive only at the first year level. Internships offer considerable direct experience in all phases of obstetrics and gynecology under the immediate supervision of the senior residents.

The obstetrics and gynecology service in 1955-56 delivered a total of 4,417 mothers with only one maternal death. In addition to the outpatient clinic operated by the hospital, resident physicians participate in pre-natal clinics operated in conjunction with the health department in scattered areas in the community.

Surgical service

The residency training program in general surgery is fully approved for four years. In addition to the surgical illnesses which are ordinarily diagnosed and treated on a general surgery service, the program includes vascular, protologic and plastic surgery, neurosurgery and otolaryngology. Rotation through anesthesia, orthopedics, surgical pathology, gynecology and pediatric surgery complete the program.

The first year resident rotates through general surgery, traumatic surgery, emergency room, and anesthesia. During the second year, the resident performs most of the major surgery on the general surgical service and the traumatic surgery service. The third year residents rotate through, and receive major operative experience in orthopedics, gynecology, pediatric surgery and may elect to rotate through general surgery at the Dallas Veterans Administration Hospital. The responsibilities of the fourth year resident include administrative and teaching duties as well as supervising other residents. In addition, he will perform major surgery which is particularly complicated or unusual. The resident may elect to spend part of the year in thoracic surgery.

Orthopedic surgery

Residents in orthopedics take three-year, rotating residencies between Parkland Memorial Hospital, Scottish-Rite Hospital for Crippled Children and Baylor University Hospital. The combination of these three hospitals is under the overall direction of the chief of orthopedic surgery at Parkland and affords a well integrated and, at the same time, a broader variation in cases than would be true if the program were limited to one of the three hospitals involved.

Urology

Urology residency training is ful-

ly approved for three years. One year of general surgery residency is a prerequisite. The first year resident in urology concentrates on acquiring skill in diagnostic methods, cystoscopic procedures, ward care of urologic patients, performing minor operative procedures and assisting at major operations.

The second year resident has ad-

ditional responsibility and performs some major surgery and is responsible for patient care on one of the divisions.

The third year, or senior resident, is responsible for overseeing the entire service, and performs the great majority of the major operations carried out. He is responsible for teaching the house staff under



Individual floor laboratories supplement the work done in the general clinical laboratories.

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Residents and interns are provided office space immediately adjacent to the nurses station.

him and medical students. An active outpatient clinic, weekly staff conference, and a journal club are additional activities.

Ophthalmology

Ophthalmology residents receive instruction in major and minor ocular surgery and perform the major portion of the operative procedures. Weekly instruction sessions are given in the basic sciences of ophthalmology throughout the training period. An afternoon seminar in clinical ophthalmology is conducted weekly for the residents by the division chairman.

In addition to the staff-attended eye clinics, the resident receives special instruction in the glaucoma clinic, ocular beta irradiation, ocular motility, and the conduction of

in-patient consultations. For six months on rotation, he attends the clinics of the Dallas Veterans Hospital and the Texas Children's Hospital, and performs surgery at both of these institutions.

Anesthesiology service

The department of anesthesiology is under the direction of the professor of anesthesiology of Southwestern Medical School. He is assisted by three full-time anesthesiologists who instruct, supervise, and assist anesthesiology residents and other resident members of the house staff from general surgery, obstetrics and gynecology, and dental departments as they rotate through the anesthesiology service. A formally organized pain clinic is staffed from this service; the handling of pain

problems with regional block anesthesia is included in the program for residents and interns.

Practically all of the anesthetics are conducted by members of the house staff. This two-year program is fully approved for American Board of Anesthesiology preparation. Anesthesiology residencies provide time for assignment to the cardio-pulmonary laboratory service. Excellent background in the handling of pediatric anesthesia is achieved by assignment to the affiliated Texas Children's Medical Center Program.

In order to carry out proper physiological monitoring of the status of patients during operative procedures the department owns and maintains a cardi tachoscope with a direct writing electrocardiograph, an infra-red carbon dioxide analyzer, an oximeter, a pneumotachograph, an electroencephalograph, and the basic equipment for respiratory function studies in pre-operative and post-operative patients. Opportunities are afforded residents in anesthesiology to carry out clinical investigative projects during their clinical training.

Radiology

The department of radiology has three full-time, board certified staff members and offers three and four year residencies in general radiology and in radiotherapy. The diagnostic section utilizes considerable general and specialized equipment, includ-

ing a biplane cinefluorograph for the production of x-ray motion pictures.

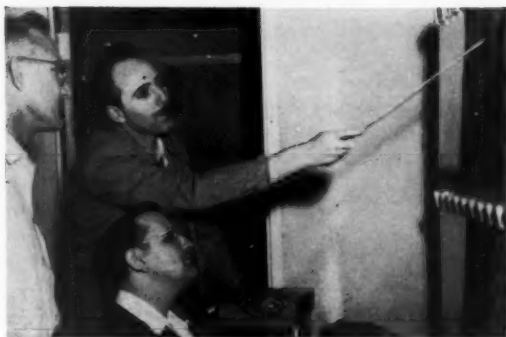
The therapy section affords training in all the usual modalities of radiation therapy, including super-voltage experience. This section also handles a considerable amount of radium work and has at its disposal 400 mgm. of radium. A complete radioisotope diagnostic, therapeutic and investigative program is being organized, and will employ the latest in scintillation counting and scanning equipment.

With the completion of the new clinical science building at the University of Texas Southwestern Medical School, the department of radiology will occupy fully equipped laboratories for basic radiobiological investigation. Residents are encouraged to do original investigative work in any of the special fields of radiology. The department maintains a full conference schedule and participates in the activities of the Parkland Memorial Hospital Tumor Clinic, which provides a rich source of material for studying the diagnosis and treatment of cancer.

Clinical laboratories

Clinical laboratories are under the combined supervision of the professor of pathology of the University of Texas Southwestern Medical School, three part-time pathologists, a full-time biochemist and toxicologist, a full-time bacteriologist and immunologist, and an in-

One of the film reading sessions, part of resident's program.



ternist specializing in infectious diseases. Residents and interns are encouraged to observe and participate in the laboratory examination of their patients, and conferences are held at regular intervals with all of the pathology department. In 1953, and again in 1954, this hospital rated in the top twenty non-federal hospitals in the nation in autopsy performance. This program is fully approved for American Board preparation.

Oral surgery

The oral surgery residency and intern training program is approved by the Council on Dental Education of the American Dental Association and also has been approved for training leading to certification by the American Board of Oral Surgery. The program offered is a two-year program leading to qualification for the American Board of Oral Surgery provided the individual has

in addition to the hospital training, completed a one year didactic basic course in oral surgery as specified by the Board. Each resident and intern rotates through the general anesthesia service for a period of two months, performs general anesthesia for dental outpatients one day a week under the supervision of the oral surgery division, attends a series of lectures on oral pathology and bone tumors under the supervision of the department of pathology, conducts an extremely busy outpatient clinic, prepares patients and conducts operative procedures in the surgery suite on the three days allotted the oral surgery service, teaches the nurses in regular classes as to expected care of oral surgery patients, instructs in the oral surgery clinic at Baylor University College of Dentistry one half day a week, attends bi-weekly complications conferences conducted by the oral surgery staff, partici-

pates in a bi-weekly journal club, arranges a scientific program for the monthly oral surgery staff dinner and conference—and in general, is taught to conduct himself with efficiency and productiveness about a hospital program.

Accommodations

A new and extremely modern staff residence provides quarters for the house staff in one wing of the building. An air-conditioned well-equipped recreation room is provided for the house staff, including television, piano, radio, etc. In addition, a private game room

has facilities for television, pool, table tennis, cards and other recreation.

Two tennis courts are located immediately adjacent to the staff residence. Season passes for access to the municipal golf courses are free to those desiring them. A number of memberships are available, at no cost to the house staff, in the Central YMCA where swimming and various sports are available. A number of the house staff serve on a rotating basis as Cotton Bowl physicians and thus get to see these games free. A number of the house staff also serve on a rotating basis as stadium

The main recreation room in the staff residence on a social evening of music and dancing.



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Getting ready for a ball game between residents and interns.



physicians for the Dallas school system for which an honorarium is received.

During the course of the year, the Margo Jones Theatre frequently makes available extra tickets for the plays presented in the theatre-in-the-round.

The women's auxiliary of the hospital operates a free coffee bar five mornings a week from 9 AM to 11 AM.

Through the generosity of a tourist court operator a short distance from the hospital, free access to the court swimming pool is available on a limited basis.

Medical and hospital care, if necessary, are provided to members of the house staff and their immediate families (wife and children) without cost.

Internships

Parkland Memorial Hospital offers 24 rotating internships and eight straight medicine internships to applicants who have graduated from an approved medical school, and have a scholastic standing in the upper or middle third of the class at the end of the junior year.

Residencies

The following resident appointments are offered.

Thoracic Surgery	1
Surgery	20
Medicine	16
Obstetrics and Gynecology ...	11
Radiology	7
Pathology	6
Psychiatry	5
Genito-Urinary Surgery	2
Anesthesiology	10

Ophthalmology	4
Neurology	1
Pulmonary Diseases	1
Orthopedics	6
Residencies are also offered in Pediatrics. Residents in Pediatrics are appointed through Texas Children's Medical Center.	

Residents and interns furnish their own uniforms consisting of white duck trousers, white coats, white shirts or short sleeve jackets. Uniform laundry is provided free.

Transportation

Parkland is located in an area where good public transportation is available at the door. In addition, the hospital operates a shuttle car service between Parkland Memorial and Woodlawn Hospitals for transportation of the house staff.

Remuneration

The base pay for interns is \$25. A monthly stipend of \$50 is paid assistant residents, \$75 to associate residents, and \$100 to chief residents.

In addition, each member of the resident and intern staff is given \$75 a month cash allowance to cover cost of such meals as are eaten at the hospital and to cover rent if the member of the house staff wishes to live in the quarters. Housing in the quarters may be obtained at the

rate of \$15 a month and meals may be obtained in any of the hospital dining rooms at maximum rates of 40c for breakfast, 50c for lunch, and 60c for dinner. Married house staff members who live at home and eat a number of meals at home also get the \$75 subsistence allowance, paid in addition to the basic stipend.

Teaching features

There are a number of features in Parkland Memorial Hospital which are specifically designed to facilitate teaching. For example, each floor, involving three divisions of 36 patients each, has a resident's office and a laboratory for special procedures for the particular service involved. Each floor likewise has a classroom in addition to the classrooms in the educational department. Each division has a house staff office immediately adjacent to the nurses station, a treatment room and a sun porch which doubles as a conference room.

Two special dining rooms are available for weekly staff conferences, chart conferences and other educational activities.

In general, throughout the hospital additional space has been apportioned to permit the necessary "room" for the house staff to function effectively.

Albert H. Scheidt, FACHA



Guest Editorial

Brain Food, Belly Food and Billfold Food

A vast majority of residencies emphasize one of these three foods. A number of hospitals emphasize two of the three, but only a very limited number emphasize all three.

Brain food, from the hospital standpoint, is limited only by the ability and willingness of its staff to teach, plus the clinical material with which to teach, plus a budget of sufficient size to permit full use of laboratory and x-ray facilities as diagnostic aids and unlimited use of drugs for therapeutic measures.

In hospitals where this phase of residency training is given paramount importance, it is not uncommon for the hospital to permit the spending of \$2400 to \$3600 per year per resident *over and above* the amount spent in other so-called teaching hospitals with the same number of admissions and approximately the same distribution of cases over the various services. While a portion of this excess expenditure is a waste insofar as the patient is concerned, it does afford the resident an excellent opportunity to verify his opinions, his conclusions and to sort out his mistakes. The frequency of use of these aids gradually builds up his



ALBERT H. SCHEIDT

Administrator,
Parkland Memorial
Hospital

confidence toward the day when he will be on his own in the practice of medicine as a qualified specialist who, from a practical standpoint, will want to order x-ray and laboratory work with much more discretion due to its financial impact on the patient.

Belly food is frequently given a disproportionate value by many residents. The difference between wholesome, relatively simple food and adequate quarters contrasted with "living high on the hog," per resident per year can easily amount to an additional \$400 per year which would otherwise be

available for teaching purposes.

Billfold food may, of personal necessity, be a factor in the selection of a residency due to such considerations as marriage, children, or other economic concerns. Nevertheless, billfold food is frequently a substitute for brain food. Many residents have a false impression that they are working for a salary rather than being given a stipend. However, when compared with what the individual could make in private practice, the so-called salary is a mere pittance if it is the primary attraction.

Unfortunately, with the formalizing of Board certification as a matter of spending so many years in a residency, plus an examination, the residency period is looked upon by many as a period of penance that must be served rather than graduate education which is not only expensive to him, but is likewise expensive to the hospital if the residency features brain food.

It is true that many hospitals do not have the opportunity to put on an outstanding teaching program and as such, feel that they should make it up to the resident in part by a higher salary, deluxe food and housing and many other non-educational trimmings.

A man who has reached the age of a resident is of sufficient maturity to make up his own mind regarding the hospital where he wishes to train.

The point I am trying to make is that a resident should

not expect a hospital to meet the highest financial bid for his services and yet expect to have unlimited opportunities for x-ray, laboratory and drug use. Turning this sentence around, the resident should not expect a hospital which affords him unlimited opportunities for x-ray, laboratory and drug use to be able to meet the high financial bid for his services where the educational factors are less available.

While the sentiment of hospital administrators is toward the resident's problem, the salary and supply costs incurred in x-ray, laboratory and the drug room cannot be paid with sentiment. At least I have never been able to find anyone who would accept it in payment. It gets to be a matter of dollars and cents, with which very few hospitals are blessed in abundance of a sufficient amount, to stand the cost of all three. There are, of course, a limited number who through endowment or other channels are among the chosen few who can, but these do not begin to be sufficient to cover the total demand for residency training. In the vast majority of cases, therefore, it behooves the resident to make up his mind as to which of these at his stage in life is most important—Brain Food, Belly Food or Billfold Food—and may your choice of your future career be successful.

The Doctor Speaks . . .

Especially designed to aid residents in history-taking and examination of foreign-born patients, an easy-to-use, compact booklet covering medical phrases, terms and questions in six foreign languages is currently available. Combining a series of language articles (French, German, Italian, Polish, Spanish and Yiddish) published during the year in *RESIDENT PHYSICIAN*, the handy booklet may be purchased at cost (single copy: one dollar). Supply limited. Address: *RESIDENT PHYSICIAN*, Reprint Department, 1447 Northern Blvd., Manhasset, L. I., New York.

Clinico-Pathological Conference

From Parkland Memorial Hospital

The patient, a colored man 22 years of age and a known diabetic for about 13 years, was admitted to the hospital in coma. History was obtained from a relative who stated that the patient had complained of headache for 10 days; swelling of the right face and eye and loss of vision in that eye for 7 days; lethargy for 3 days; and coma for 12 hours.

The immediate present illness began some 10 days prior to admission when the patient began to complain of a severe generalized headache for which no relief could be obtained by aspirin and bed rest. His headache became increasingly severe; and seven days prior to admission his

right eye and the whole right side of his face were swollen. A physician gave penicillin once.

Progressive diminution of vision in the right eye continued. About three days prior to admission it was noticed that the patient had become more lethargic and was slow to respond.

About two days prior to admission he experienced sweating, hunger and nausea for which orange juice was given with complete relief of the symptoms. The lethargy continued, however, until the day prior to admission, when he was awakened with difficulty. He could not be aroused the following morning and was brought to the hospital.

This report was prepared for publication in RESIDENT PHYSICIAN by the staff of the Department of Pathology, Parkland Memorial Hospital, Dallas, Texas.

Previous admissions

Past history revealed that the patient had been hospitalized for the first time about 16 years ago for a herniorrhaphy. At that time the urine was free of sugar and acetone. About two years later he began to have typical symptoms of diabetes, including polyuria, polydipsia, polyphagia, weakness, and lethargy.

He was brought to the clinic, where a diagnosis of diabetes mellitus was made. He received 40 units of insulin a day, half PZI and half regular.

The patient remained fairly well until six months later, when he was hospitalized because of diabetic coma.

During the next six years he was admitted many times to the hospital in diabetic coma. These admissions lasted from two to six months, during which time the insulin dosage varied between 45 and 90 units of mixture of PZI and regular insulin. The same dosage on some days produced hypoglycemic shock and on other days did not control hyperglycemic symptoms at all.

After each of many such admissions, the patient would be discharged at the conclusion of several months in the hospital, only to be brought back on the following day in coma again. During these admissions, infection was implicated in the pathogenesis of the coma on only two occasions.

Once, about a year after onset of diabetes, the patient had an episode

of bronchopneumonia, and on another occasion he was found to have pyuria. Sporadically, during these hospital admissions, he exhibited 1+ to 4+ albumin in his urine. On other occasions there was no albumin.

About eight years after the onset of diabetes the BUN was found to be 12 mg.%. Blood pressure levels recorded at that time were within normal limits. About 10 years after onset of diabetes he was admitted again in diabetic coma and laboratory studies at this time showed normal BUN and blood pressure varying from 140/90 to 130/85. After three months hospitalization the patient was discharged on 90 units of insulin, 45 units PZI and 34 units of regular, with occasional supplements of 15 units before his mid-day meal when needed.

Throughout these many hospital admissions the patient was never well controlled and often went from coma to shock in a period of a day. During the four years prior to the last admission not much is known about the patient.

Examination

At the final admission the patient was observed to be undernourished and moribund. The most striking manifestations were proptosis of the right eye with swelling of the right side of the face, bluish discoloration of the nose, and deep, rapid, labored respirations. BP 170/110, pulse 130, resp. 24 and temperature

102°. The eye was marked proptosis of the right eye with whitish-creamy conjunctival exudate. The conjunctiva was injected and there was a large conjunctival hemorrhage on the medial aspect of the eye. The anterior chamber was opaque and did not transmit light. The fundus could not be seen on the right. The right eyelid exhibited a bluish discoloration which extended over the bridge of the nose and down the right side of the nose.

The left eye was clear except for slight clouding of the anterior chamber. Examination of the left fundus disclosed marked arteriolar narrowing and A-V nicking with numerous hemorrhages and exudates; the disk was thought to be blurred. The pupils were round and equal but did not react to light. The ears were normal.

There was a 2 x 4 cm. membrane on the right side of the hard palate. The membrane was greyish-white in color and stripped with ease, revealing a hemorrhagic area.

The neck was very stiff. No masses in the neck were felt. Respirations were irregular, deep, and labored, with periods of apnea lasting 10 to 15 seconds. Respiratory rate was 24 per minute. The respirations were sonorous at first; this was relieved completely by an oral airway. There were a few scattered crepitant rales in the right base. The PMI of the heart was 1 cm. outside the midclavicular line in the 5th intercostal space. The left

border of the heart was just outside the PMI. The heart rate was regular. Normal sinus rhythm was present with a rate of 130 per minute. BP was 170/110. There was a Grade I systolic murmur at the apex.

The abdomen was protuberant; bowel sounds were absent; there was dullness up to the umbilicus, thought to represent a distended bladder. The liver was palpable two fingers breadth below the right costal margin. The spleen was not palpable.

Deep tendon reflexes were absent in the left arm and leg and hypoactive on the right. Superficial reflexes were absent on the left and diminished on the right. There was a Babinski reaction on the left. The patient did not respond to sensory stimuli anywhere over his body.

Hospital course

Laboratory work on admission revealed a white count of 18,500; differential, 17 polymorphonuclear band forms, 68 polymorphonuclear segmented forms, and 15 lymphocytes. Hgb. was 7 gms. The urine contained 4+ albumin, 2+ sugar and 2+ acetone.

Blood sugar drawn at that time was 225 mg.%, BUN was 114 mg.%, chlorides 96 mEq., CO₂ 18 mEq.

Cultures were taken from the blood, the urine, the right eye, nose, mouth and oral lesion previously described. During the time the cul-

tures were being drawn, the respirations became more labored. Supraclavicular and intercostal retraction became apparent and the rales in the right base increased in number. It was thought by the members of the medical and surgical staff that this patient needed a tracheotomy; accordingly, this was done.

Approximately four hours after the tracheotomy, despite almost constant suction, the patient's respirations became more labored and it was noted that he was having difficulty in the expiratory phase. Radiographs taken at this time were interpreted as showing segmental areas of atelectasis.

Twenty-four hours after admission the patient began to expectorate a frothy pink material which was thought to represent the effect of pulmonary edema. He was rapidly digitalized. The PMI shifted to approximately 1 cm. closer to the midline; however, there was no relief of his labored respiration.

On admission a spinal tap was done which revealed an opening pressure of 190 mm. of water, the fluid containing 200 white cells and 90% lymphocytes. At the 24th hour, after a rise in blood pressure from 170/110 to 240/170, a lumbar puncture was again done. The opening pressure was 390 mm. of water and there were 400 white cells, about 90% of which were lymphocytes.

During the hospitalization of 30

hours he received some 7 liters of fluid consisting of 3 liters of Ringer's lactate, 3 liters of 5% glucose in water, and 1,000 cc. of fresh whole blood. Additional intravenous medication included 105 units of regular insulin, 20 million units of penicillin, 4 gms. of achromycin, and 3 gms. of streptomycin, 100 mg. of ACTH and 100 mg. of cortisone.

Blood sugars at 4-hour intervals varied between 160 and 190 mg.%. The urine continued to contain 1 to 2+ sugar and acetone ranging from a trace to 1+.

By the 24th hospital hour, bacteriologic study had revealed no growth from the nose, ears, or mouth. Shortly after, the patient had a generalized convulsion lasting approximately three minutes, during which the heart ceased to beat. After cessation of the convulsion, the patient gasped three or four times and expired. Spinal fluid cultures produced no growth.

Post

Necropsy revealed proptosis of the right eye and acute inflammation of the right orbit and the skin of the right side of the face. The ethmoid sinuses contained sanguinopurulent material. The cranial bones and the meninges of the brain were grossly normal. In the right frontal lobe of the brain was a large area of necrosis, the cerebral tissues appearing granular and friable. Similar but smaller areas of necrosis were present in the right

temporal lobe and the right cerebellar hemisphere.

In sections of the orbital contents and of the necrotic parts of the brain there were numerous thrombosed veins filled with fungal hyphae and surrounded by an inflammatory reaction composed mostly of lymphocytes. In the absence of a satisfactory culture it is difficult to be certain of exact identification of the fungus. On morphologic study, however, it is thought most likely that the organism in this case was a species of mucor.

Each kidney weighed 140 grams. Their surfaces were finely granular. Microscopic examination revealed severe intercapillary glomerulosclerosis.

There was a tracheotomy incision, and the lungs were congested and moderately edematous. A moderately severe, non-specific bronchopneumonia was present upon microscopic examination.

The pancreas was normal grossly and microscopically.

Other significant anatomic findings included ascites, bilateral

pleural effusion, slight generalized arteriosclerosis and surgical absence of the appendix. The heart weighed 340 grams.

The occurrence of cerebral and orbital mucormycosis in severe diabetes is being reported with increasing frequency and probably cannot be considered a very rare disease. The infection may possibly originate in the nasal sinuses and extend to involve intraorbital and intracranial structures. The appended references describe cases of similar type.

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Many, many interesting things some sad, some pleasant — have happened to me as secretary for surgical residents. But by all odds, my first day at work was the wildest — and in retrospect, the most wonderful

Residents Are The *Craziest* People!

There are many members of the hospital team. One of a group often overlooked tells how she became a part of the team. She also issues an invitation—and a warning.

When a resident begins work in a new hospital, he feels uneasy until he gets to "know the ropes."

But when a greenhorn secretary, who never worked in a hospital, begins work in the same hospital—residents sure can add to her age in just a few easy lessons. This, of course, applies to a particular group of residents I wish to describe.

My experience is one that I hope will make a resident look at his new secretary and say to himself, "I'll have to take it easy on this

old gal," or "... young chick"—as the case may be.

My first day as surgical secretary will never be forgotten. Not by me nor, I suspect, not by many others on the service at that time.

I had just met the entire surgical staff for the first time at a conference which had been called in my office. During the conference, one restless resident (who had been regarding me with a strange glint in his eyes) suddenly left the room.

A few minutes later he returned carrying a huge porcelain tray. And

on this tray was a large and blood-covered something or other. My mouth opened to scream as he walked toward my desk; I felt my stomach reaching to the top of my head. I was virtually paralyzed. He plunked the tray on my desk with a thud that splattered blood all over the desk top and he said with enthusiasm, "Miss Morgan, really now, isn't that the most beautiful specimen of cancer you could ever hope to see?"

Initiation

I bolted from the room and headed for the ladies room. I didn't come out until the conference was over. The chief resident had remained to apologize but even as he did, I had a feeling that there would be more to my initiation.

An hour later, still shaken, I heard laughter from the room adjoining my office. After listening for a matter of many minutes, my curiosity got the better of my discretion. I opened the door—and instantly recoiled in horror. Pushed up next to the door was a table

The authoress writes:
"Would prefer my name not be used if that is possible. If it is necessary, I don't mind because every word is the truth." We, of course, yield to Authoress X in her request for anonymity.

upon which was a deceased male, covered with a sheet from toes to waist. I slammed the door and returned to my desk. In a moment, I again felt ill and rushed to the ladies room.

A few hours went by before the Heap Big Chief resident returned. He said very sternly, "Take a letter please."

He then proceeded to dictate a letter which I realize today must have contained all of the longest medical words he could muster and which, when put together, didn't make one word of sense.

Incidentally, it took me three days to finish the letter.

Another door

He had no sooner finished dictating the letter and left the office, when I heard my name called from the adjoining room. You can readily understand that I hesitated to open the door. The voice became louder and more commanding. Finally, I opened the door, felt a hand grab my wrist and in a wink, I was in the room and directly facing the field of withdrawal of a proctoscopy tube. My knees buckled. As my body almost reached the floor, I felt myself being dragged back into the office. The windows were opened and I was given a glass of water.

My vision returned slowly, yet suddenly, instead of being angry, my heart went out to the three pacing residents who were extremely worried. Weakly, I said

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something stupid like "Hello" which brought sheepish grins from all three. It was only a matter of moments until the entire staff had gathered to welcome me on the team. From that time on, we became real teammates.

I will remember this particular

group of residents because of their insane, sadistic sense of humor. I will also remember their real warmth and keen understanding. I hope that another such group of residents will come in in July.

But I'll be ready for them this time—I hope . . .



"All I did was say 'Good Morning' "

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Note: The saving of time, work, and money by closed-system injection in the hospital has been determined by exhaustive published studies. The most recent, by J. A. Hunter, et al., is available upon request. See your Wyeth Territory Manager or address Wyeth Laboratories, P.O. Box 8299, Philadelphia 1, Pa.

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CLOSED-SYSTEM INJECTION

Current Practice Openings: State by State

MANY residents graduate this month. Most have already made definite plans for the future, some going on for an additional year of residency or fellowship and others into practice either as a partner or solo. But there are also great many residents whose plans haven't quite jelled and who now find themselves wondering about the immediate future. For these "unlocated" physicians, your journal has compiled this tabulation of information recently obtained by your editors through correspondence with state medical societies. We hope it will motivate you to write a few letters in search of the many excellent practice opportunities ready and waiting for you. Most states operate extensive placement programs. Many are able to provide you with valuable assistance and detailed descriptions of openings.

Note: *Formal* listing usually indicates that a brochure is published at regular intervals which summarizes the nature of opportunities available in the state. An *informal* listing often means that the society, though willing to help you where possible, does not maintain a complete list covering all opportunities in the state. They will, however, advise you of any openings which come to their attention.

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
Alabama	Formal	21	25	Physician Placement State Medical Association 17 Molton Building Montgomery, Alabama
Arizona	Informal	8	12	826 Security Building Phoenix, Arizona State Medical Association
Comment: "We maintain 'Locations Available' listings."				
Arkansas	Formal	2	21	Arkansas Medical Society 218 Kelley Building Fort Smith, Arkansas
Comment: "Physicians may contact us for full information."				
California	Formal	2	31	State Medical Association 450 Sutter Street San Francisco, California
Colorado	Formal	7	10	State Medical Society 835 Republic Building Denver 2, Colorado
Connecticut	Formal	0	20	Placement Service 160 St. Ronan Street New Haven, Connecticut
Comment: "Refer physicians seeking locations for general practice."				
Delaware	Informal	5	3	Medical Society 621 Delaware Avenue Wilmington 1, Delaware
Comment: "Supply and demand operating well."				

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
District of Columbia	Informal	3	1	Medical Society 1718 M. Street, N. W. Washington 6, D. C.
Comment: "Few openings because of large number of physicians per population."				
Florida	Informal	2	15	Medical Association P. O. Box 2411 Jacksonville, Florida
Comment: "At the present time we do not believe there is any urgent need for additional medical service in Florida, except in a few isolated small towns which do not seem to appeal to physicians seeking a location."				
Georgia	Informal	18	27	Medical Association 875 W. Peachtree St., NE Atlanta 9, Georgia
Idaho	Formal	3	12	State Medical Association 364 Sonna Building Boise, Idaho
Illinois	Formal	30	134	Placement Service State Medical Society Attention: Harold M. Camp, M.D. Monmouth, Illinois
Comment: "Physicians are invited to write us concerning our program."				
Indiana	Formal	60	1	State Medical Association 1021 Hune Mansur Bldg. 23 East Ohio Street Indianapolis 4, Indiana
Comment: "We would be happy to supply a list of openings, on request."				

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
Iowa	Formal	20	60	Iowa State Medical Society 529 36th Street, Des Moines, Iowa
Comment: "Contact us when searching for a practice."				
Kansas	Formal & Informal	10	20	Kansas Medical Society 315 West 4th Street Topeka, Kansas
Kentucky	Formal	10	20	Delmas M. Clardy, M. D., State Medical Association 620 South Third Street Louisville, Kentucky
Louisiana	Informal	2	14	Dr. C. Grenes Cole State Medical Society 1430 Tulane Avenue New Orleans, Louisiana
Maine	Formal	Oppor- tunities in all special- ties	78	Maine Medical Association Box #240 Brunswick, Maine
Comment: "Publish 3 or 4 times a year a brief summary of locations information. If you wish, we will send up-to-date information to you."				
Maryland	Informal	None	35	Secretary, Medical and Chirurgical Faculty of the State of Maryland Baltimore, Md.

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
Massachusetts	Formal	4	12	Placement Department Massachusetts Medical Society 22 Fenway Boston 15, Massachusetts
Comment: "The Society operates a placement bureau and is interested in helping physicians locate. Most of the openings for G.P.'s are in rural areas outside of Boston."				
Michigan	Formal	45	119	Michigan Health Council M.D. Placement Service 706 N. Washington Ave. Lansing 6, Michigan
Comment: "List of openings available on request. We operate a free doctor placement program in Michigan."				
Minnesota	Formal	42	161	State Medical Association 496 Lowry St. Paul 2, Minnesota
Comment: "We maintain an active placement service for physicians."				
Mississippi	Formal	0	0	State Medical Association P. O. Box 4322 Jackson, Mississippi
Missouri	Formal	10	50	State Medical Association 623 Mo. Theater Bldg. St. Louis, Mo.
Montana	Informal	0	10	Montana Medical Association P. O. Box 1692 Billings, Montana
Comment: "We publish a special bulletin with biographical data of physicians seeking a location. This bulletin is sent to all interested communities and to physicians and clinics seeking associates, assistants or staff members."				

in urinary tract
infections of pregnancy
delay is dangerous...

*"Approximately one-half of
the patients have some permanent
damage to the urinary tract."¹*



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BRAND OF NITROFURANTOIN

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FOR RAPID ERADICATION OF INFECTION

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AVERAGE DOSAGE: 100 mg. q.i.d. with food or milk. Continue for 3

days after urine becomes sterile.

SUPPLIED: Tablets, 50 and 100 mg. Oral Suspension (25 mg. per 5 cc. tsp.).

REFERENCES: 1. Rives, H. F.: *Texas J. M.* 52:224, 1956. 2. Diggs, E. S.; Prevost, E. C., and Valderas, J. G.: *Am. J. Obst.* 71:399, 1956. 3. MacLeod, P. F., et al.: *Internat. Rec. Med.* 169:561, 1956.

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frequently occur in and are aggravated by.....**

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and other
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**certain
respiratory
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bleeding;
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specific aid in
the prevention and
correction of
capillary fault
in such conditions**



C.V.P.

Each C.V.P. capsule
or each 5 cc. of syrup
(approx. one teaspoonful) provides:
Citrus Bioflavonoid Compound . 100 mg.
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capsules: bottles of 36, 100, 500, 1000
syrup: bottles of 4 oz., 16 oz. and gallon

new!

duo-C.V.P.
(double strength C.V.P.)

Each duo-C.V.P. capsule provides:
Citrus Bioflavonoid Compound . 200 mg.
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C.V.P.
and
duo-C.V.P.
(double strength C.V.P.)

C.V.P. helps diminish increased capillary permeability, fragility, and resultant bleeding by acting to maintain the integrity of the intercellular ground substance (cement) of capillary walls. C.V.P. is water-soluble and is thus readily absorbed and utilized. Purified hesperidin and rutin are poorly soluble in water. Hesperidin itself has been shown to be inactive in a number of biologic tests, in which C.V.P. is highly active. C.V.P. provides the many active water-soluble bioflavonoid factors of the whole citrus bioflavonoid complex.

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STATE	LISTING	OPENINGS	Specialty G. P.	FOR FURTHER INFORMATION
Nebraska	Formal	8	21	Nebraska State Medical Association 1315 Sharp Building Lincoln 8, Nebraska
Comment: "We are glad to hear from residents or doctors looking for a location. Nebraska is a good place to practice. Mostly we need general practitioners who wish to practice in small towns. It is a rewarding service in Nebraska."				
Nevada	Informal	6	4	Nevada State Medical Assoc. (for G.P.'s) P. O. Box 188, Reno, Nevada
Comment: "Clark County, Nevada (Las Vegas), is a rapidly growing community of 75,000 persons. Several specialties are not represented there: Psychiatry, Anesthesiology, etc. For inquiries write Ivan W. Kazan, M.D., Clark County Med. Soc., 1100 Arizona St., Boulder City, Nev."				
New Hampshire	Formal	3	14	New Hampshire Medical Society 18 School Street Concord, New Hampshire
Comment: "We conduct a survey of towns and cities in this state once a year and work with citizen committees, aiding them to secure adequate medical coverage. There are several excellent opportunities for G.P.'s in this state."				
New Mexico	Formal	1	15	New Mexico Medical Society 302 First National Bank Albuquerque, New Mexico
New York	Formal	3	49	John H. Iselin, Jr., M.D. Placement Bureau, Medical Society of New York 386 Fourth Avenue New York 16, New York
Comment: "We would be glad to provide copies of our lists of opportunities for interested physicians."				

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200-mg.
SHIELD-
SHAPED
TABLET

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STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
North Carolina	Formal	15	80	Medical Society of North Carolina P. O. Box 790, Raleigh, N. C.
Comment: "We have placement service available."				
North Dakota	Informal	7	15	State Medical Association Lock Box 1198 Bismarck, North Dakota
Ohio	Formal	very		Director of Placement Service
	Informal	few	many	State Medical Association 79 East State Street Columbus 15, Ohio
Comment: "We will help all we can with problems of finding a location."				
Oklahoma	Informal	5	10	Oklahoma State Medical Association Box 9696 Shartel Station Oklahoma City, Oklahoma
Comment: "We prefer personal discussion with interested physicians rather than sending out lists and discussing opportunities by correspondence alone. However, we would appreciate referrals from you."				
Oregon	Formal	18	40	Oregon State Medical Society 1115 S. W. Taylor Street Portland, Oregon
Comment: "Oregon maintains an active Physician Placement Service."				
Pennsylvania	Formal	5	50	Physician Placement State Medical Society 230 State Street Harrisburg, Pennsylvania

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
Rhode Island	Formal	0	0	R. I. Medical Society 106 Francis Street Providence 3, R. I.
South Carolina	Informal	1	11	Dr. Robert Wilson 165 Rutledge Avenue Charleston, S. C.
South Dakota	Formal	8	39	State Medical Association 300 First National Bank Bldg. Sioux Falls, South Dakota
Tennessee	Informal	2	18	Public Service Secretary State Medical Association 112 Louise Avenue Nashville 5, Tennessee
Comment: "Physicians' inquiries invited."				
Texas	Formal	35	65	Texas Medical Association 1801 North Lamar Boulevard Austin, Texas
Comment: "Great opportunities available in rural practice."				
Utah	Formal	0	5	State Medical Association 42 South 5th East Salt Lake City, Utah

STATE	LISTING	OPENINGS		FOR FURTHER INFORMATION
		Specialty	G. P.	
Vermont	Informal	5	10	State Medical Society 128 Merchants Row Rutland, Vermont
Virginia	Formal	25	60	Virginia Council on Health & Medical Care 102 East Franklin Street Richmond 19, Virginia
Comment: "Would like to hear from resident physicians who might be interested in locating in Virginia."				
Washington	Formal	3	32	State Medical Association 1309 Seventh Avenue Seattle, Washington
West Virginia	Informal	0	10	State Medical Association Box 1031 Charleston 24, West Virginia
Wisconsin	Formal	34	109	Placement Service State Medical Society Box 1109 Madison, Wisconsin
Comment: "Inquiries invited."				
Wyoming	Formal		12	Wyoming State Board of Medical Examiners New State Office Building Cheyenne, Wyoming
Comment: "Write to this office."				



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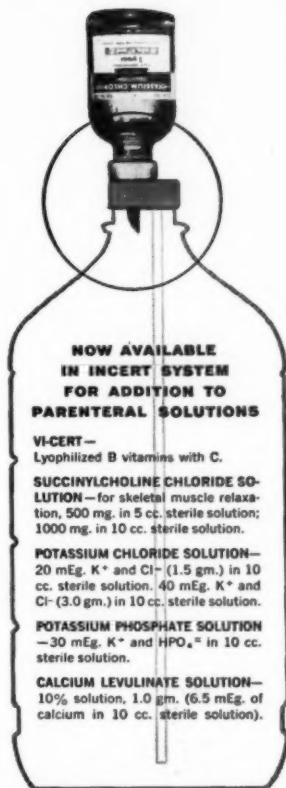
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SUCCINYLCHOLINE CHLORIDE SOLUTION—for skeletal muscle relaxation, 500 mg. in 5 cc. sterile solution; 1000 mg. in 10 cc. sterile solution.

POTASSIUM CHLORIDE SOLUTION—20 mEq. K^+ and Cl^- (1.5 gm.) in 10 cc. sterile solution. 40 mEq. K^+ and Cl^- (3.0 gm.) in 10 cc. sterile solution.

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CALCIUM LEVULINATE SOLUTION—10% solution, 1.0 gm. (6.5 mEq. of calcium in 10 cc. sterile solution).

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Mr. Dare's Self-Surgery Machine

Surgical residents may tremble—but not, we hope, with fear. The spell of spring induced this whimsical excursion. Fact or fancy? Perhaps our generation will never know.

SOMEHOW, in the spring, we anticipate summer. And though it's not really warm outside, our door is left open in the afternoon to catch an early spring breeze having a scent of magnolia and the clean smell of grass, free of winter's hold. It's a waking up time for most of Nature. Yet, what human can be fully awake on balmy days such as these?

Thus it was with us last week that our door was open, the breeze invited. And, somehow, our chin was bumping our chest as thoughts drifted, without pattern or purpose, through our sleepiness. Fish were leaping from a cool Wisconsin lake, a tee shot straight and long to the green, the hum of the lawnmower. . . .

. . . And suddenly, we had a visitor. Abruptly, we sat up as he spoke his name.

"John K. L. Dare," he said with neither pride nor undue reticence.

"Doctor?" we asked, wondering how long he had been standing by our desk. "No," he said firmly. "I'm an inventor and a humanitarian."

Without waiting for further pleasantries, Mr. Dare was invited to sit down. We are often busy. Hardly ever are we rude.



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relief in minutes... Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours... Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

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Theophylline..... 2 gr.
Ephedrine HCl $\frac{3}{8}$ gr.
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"I have," he said in a matter-of-fact tone, "an invention, one which will completely revolutionize the practice of surgery all over the world."

Mr. Dare's voice was soft, without trace of any particular accent. He appeared to be about 60, tall, spare and with bright, blue eyes. His gray-hair was neatly combed and parted. A clean white handkerchief edged the breast pocket of his suit of charcoal gray flannel—the kind with those narrow lapels and three buttons, once the hallmark of the young advertising executive on Madison Avenue.

He was, however, not an advertising man—he had already told us he was an inventor "and a humanitarian."

"I have just returned from Washington where I checked on my patent application. Mine is a remarkable machine."

"A machine?" we asked. "What kind of a machine?"

"Perhaps," he said smiling indulgently at what he took to be our eagerness, "I had better begin at the beginning."

As the idea seemed reasonable, we said nothing.

"My home," he began, "is about 14 miles up from Anchorage, Alaska. The heat here bothers me some," he added with a quick smile.

Though we weren't aware of the heat before, we suddenly began to feel a bit warm . . . and more than just a bit nervous, too.

Automatic

"It was up there," he nodded in the direction of our north window, "that I first got the idea. And today, I have it all set and operating. It's a self-contained, automatic, electrically operated machine which will perform every known surgical operation currently being attempted on the human anatomy." He looked at us expectantly.

Again, since we could think of nothing to say, we said nothing.

"That isn't all," he continued. "The machine is run by the patient. He operates on himself."

Now we were really nervous. What made it worse was that Mr. Dare was between us and the door. We gripped the arms of our swivel chair and waited for the next development.

Mr. Dare seemed not to notice our growing discomfiture. He continued, proudly, "I've been working on this machine for 13 years—and now it's ready."

We began to perspire profusely.

"I don't wonder it excites you," said Mr. D., "it's been a long time coming. Anyway, here it is. . . ."

With this, he pulled from his coat pocket a long cylinder of paper, fastened around with string. It was now apparent he meant us no personal harm. We stood up and looked over his shoulder as he slipped off the string and spread the paper on our desk.

It was a detailed blueprint of the most amazing-looking machine you could possibly imagine.

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Delfen
VAGINAL CREAM

used with a measured-dose applicator
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wider patient acceptance.



Triumph

"This," he said with some emotion, "has long been my dream—to perfect a machine for those who cannot afford the surgeon's skill and for those who are too far from hospitals to reach them quickly in an emergency."

As our eyes, unfamiliar with blueprints, began to discern some of the ingenious details of the device, we became more and more fascinated by what we saw.

"In most every other kind of emergency," he was saying, "man is self-sufficient, able to act for himself as he must when the electricity goes off in his house, the well freezes or the toilet gets stopped up."

We nodded, absorbed in the blueprint.

"Well, this represents the final triumph of surgery, the last frontier of the do-it-yourself trend of our time. As you can see, the possibilities are virtually limitless."

A question began to form in our mind. Would it work? *Could it possibly work?*

Mr. Dare was saying "... This is the culmination of a boyhood dream."

To have such dreams as these as a boy. How misspent our own youth by comparison.

"If you'll follow my finger, I'll explain the operation of the machine."

Obediently, our eyes shifted to his extended forefinger.

"In operation, it's really very simple. A moron could run it," he added

with a chuckle. We managed to force a little chuckle of our own but it didn't come off very well.

"There is," he went on, "some uncertainty connected with its use." Somehow we knew there would be.

"Yet, it has been tested, and considering some of the stupid people who tried it, I think the record speaks for itself."

"You mean," we asked carefully, "you actually have a model built and it has been used on human beings?"

"Of course. Who do you think it's designed for if not for humans? Certainly I have a model built—do you imagine this to be some hair-brained scheme of a visionary, without substance? Meaningless? Why certainly there's a model... a working model, too." He appeared to have been disturbed by our question.

Procedures

Determined to smooth his ruffled composure, we said, "How many procedures have been attempted by your marvelous invention?"

"I'm glad you brought that up. Let me see. . . ." He hesitated, looked at the ceiling, put his finger on his chin and continued, "... yes, yes, I have it now. So far, it has been tested with fourteen operations. These consisted of four appendectomies, two craneotomies, two lithotomies, one thyroidectomy, hysterectomy, pneumonectomy, hemorrhoidectomy, one fistulectomy... the latter two on the same patient at the

effective urinary analgesia



you can quickly stop pain, urgency,
frequency and burning

Whenever urinary tract infections, strictures, obstructions, fistulas, stones, trauma or neoplasms cause painful mucosal lesions, you can provide relief quickly (within 20-25 minutes) with Pyridium. Pyridium is compatible with and complementary to all the urinary antibacterials and permits greater flexibility in the use of any combination, potency or dosage schedule required for successful treatment. Dosage: Two tablets before each meal. Supplied: in bottles of 12, 50, 500 and 1000.

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acting, oral form of ACHROMYCIN® Tetracycline — offering you

patients, on the average, twice the antibiotic absorption in half

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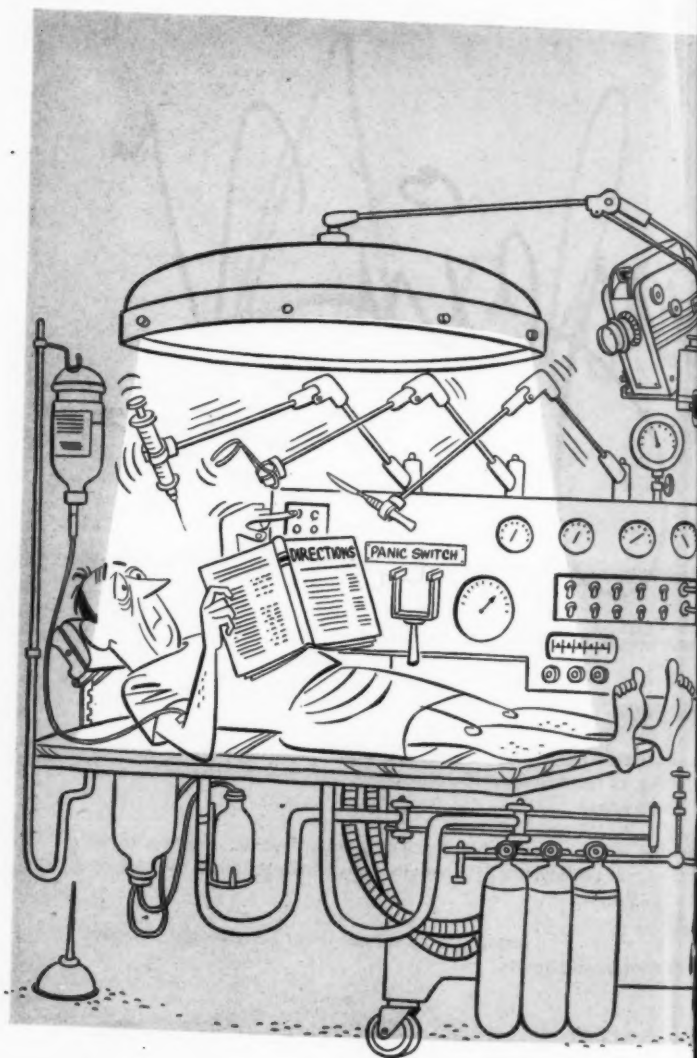
broad- **CHROMYCIN V** Tetracycline Buffered with Phosphate

rapid- **CAPSULES**—Each capsule (pink) contains tetracycline equivalent to 250 mg. of tetracycline HCl, phosphate-buffered. Bottles of 16 and 100 capsules.

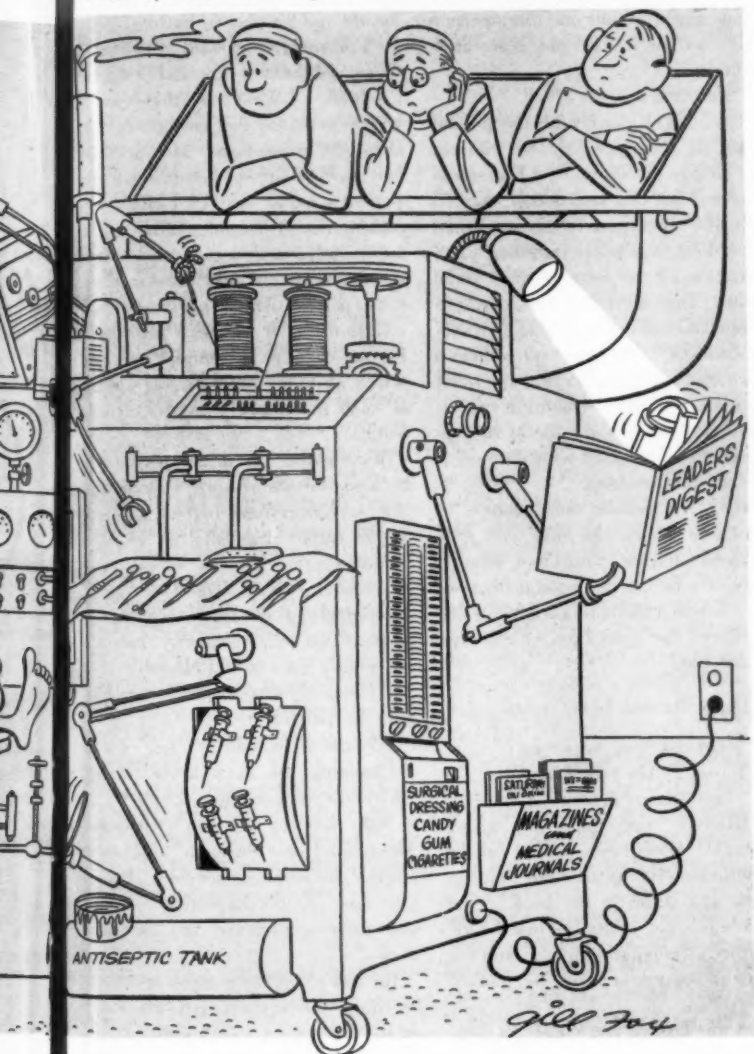
g your **SYRUP**—Each teaspoonful (5 cc.) of orange-flavored syrup contains 125 mg. of tetracycline HCl activity, phosphate-buffered. Bottles of 2 and 16 fl. oz.

in half **CHROMYCIN V** dosage: 6-7 mg. per lb. of body weight per day for children and adults.

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"There is, of course, the question of board certification"



same time . . . and one circumcision . . . on an 87-year-old man, incidentally."

"The results . . . ?"

" . . . Well, as I said, the patient does all the operating on himself. He simply pushes control buttons as directed by the instruction manual and the operation is accomplished according to a pre-determined plan, imitative of the best surgical technique. But, there are a lot of stupid people around—and of the fourteen procedures," Mr. Dare proclaimed, "two could be considered unqualified successes. Of the remaining twelve, eight expired on the table of various causes not connected with the operation or the machine."

We were anxious once more.

"Three others," he said with pronounced disgust, "required emergency care later in a hospital because they botched the thing right in the middle of the procedure. Sheer stupidity, too."

LW-33

"What did they do wrong?"

"Wrong?" He raised his voice for the first time in our interview. "WRONG? They push the wrong buttons! How dumb people can be sometimes. It was all right there in black and white in the book. One man was right in the middle of his middle . . . a laparotomy . . . and for some impossible reason, he pushed LW-33."

He was flushed and visibly shaken. We gently inserted a query as to the

nature and purpose of button LW-33.

"I'm sorry," he said quickly. "I forgot you aren't familiar with the machine. LW-33 is the control which actuates the emergency tracheotomy procedure. The depth of cut must be pre-set according to the patient's collar size . . . either circumference or diameter of neck. Unfortunately, in this case, the control for depth of cut was set for maximum penetration. The patient was a little man. It was very unpleasant for me to have to stand there and watch while my machine was abused in such a manner! Stupid, stupid people."

We cleared our throat which had become uncomfortably constricted. We were beginning to feel like one of the stupid stupids.

Moving quickly to other trial cases, Mr. J. K. L. Dare of Alaska mentioned that the last patient in the series "just quit halfway through. He simply got out and closed."

Dare curtly dismissed the incident and the patient.

"No guts," he said.

Changing the subject, we asked "What do you call the machine?"

"Oh, didn't I tell you? It's the American Home Surgeon. Like it? I think the name is suitable. Patriotic, too. That's important. Gives one more confidence in the machine."

He was silent for a moment. Then he said, "After the fourteenth case on the machine, I wasn't able to find anyone who needed surgery in my

locality. I guess not many people require any operations in my part of the world. Healthy group. Besides, I've taken care of most of them . . . say, here's a folder describing the machine. Read it over for a minute, it'll give you a better idea of just how it works."

Obediently, we opened the folder and read:

"Made to clamp on almost any kitchen table (deluxe model available with table included), the American Home Surgeon includes three scalpels suspended on jointed aluminum tubing, retractors, hemostats, and a revolving drum of ten syringes which can be individually controlled by the patient-operator for the administration of local anesthetic. Also, the American Home Surgeon has a unique pump and sump for blood collection, with provision for returning lost blood to an elevated intravenous bottle for infusion.

Note: This unique device can be adapted for the do-it-yourself transfusion whenever necessitated by any excessive bleeding during the operative procedure.

A footnote explained "though a perfectly dry field is seldom possible, excessive bleeding should not occur if the patient-operator follows operative directions closely."

Knots

Other items described included: "an aluminum arm with a rotating brush having its own supply of surgical soap, and a branch arm

holding a brush for the application of antiseptic solution for the area of incision."

Under the heading "Sew-Sew-Section," the following are listed: ". . . two needles (cutting and non-cutting), two mechanical, automatically-controlled fingers for knot tying, four types of suture material, selected prior to the operation by the patient-operator."

Mr. Dare interrupted our reading. "A few things have been added since that was printed. For example, with all models is a movable mirror, ten by fifteen inches, so that the patient-operator may watch his own operation and thus detect any flaws in technique. Also, on the deluxe model, a sixteen mm. movie camera and floodlight is available as an optional item at a slight extra cost. This makes it possible for the patient operator to photograph his operation, perhaps later selling it to any of a number of national magazines or possibly, national TV programs interested in dramatic medical material."

We went on with our reading. ". . . a complete step by step course to be followed in the operation of the Dare Automatic Home Surgeon."

In the book, first things quite logically come first. "The patient," we read, "is obviously put under no strain since all he must do is push buttons according to the code indicated by this instruction booklet."

At this point, Mr. Dare told us that soon he may convert his machine

to an IBM installation, whereby the type of operation can be prepunched on cards and simply inserted in the machine. "The patient then may passively watch the whole procedure without even pushing buttons," he declared with enthusiasm.

Variables

On his present model, Mr. Dare said "certain quantities are variable." For instance, the length of the incision may be selected.

"Some patients," Mr. Dare observed, "often prefer a four or five inch incision for an appendectomy so that they may properly portray the evidence of having had an operation. Others prefer, for cosmetic reasons, a small incision."

Other contingencies are allowed for. For example:

"... even with careful pre-op x-rays, cystoscopies, and intravenous

pyelogram, a stone will sometimes move just before or while the incision is being made. Often this presents a rather knotty problem of locating the stone exactly."

However, Mr. Dare feels his machine has this detail licked. His book contains this inspiring advice under the chapter "Lithotomy, uncomplicated: Occasionally, when the two-fingered hand probe enters the field, the stone is not immediately located. Now relax! You have plenty of time if you don't panic. Repeat, don't panic. Simply press S-1, S-2 and S-3 buttons, one after the other. This will gently oscillate the two-finger probe laterally, horizontally and vertically. When contact with the stone is made, the stone retracting forceps will automatically move to the point of the stone and pluck it out."

Immediately following this para-



graph is a section designated "Emergency— . . ."

" . . . If after pushing S1, S-2, and S3 nothing happens, push Z-19. Z-19 is not a button to be pushed indiscriminately; this is what we term the PANIQUE button. In other words, there are no more buttons to push after this. And if this doesn't work, you've had it. However, so far it has never failed and you may take courage from this fact," the booklet reports, bravely.

Mr. Dare explained: "What Z-19 does is retract the two-fingered probe, inserting the special seventeen fingered probe into the incision. Incidentally the seventeen fingered probe, as an accessory, is not included with the standard model. I do recommend its purchase, though. . . . Now with the seventeen fingered probe, success is assured. Either the stone will be found immediately or you never had a stone in the first place and you shouldn't be doing this operation."

Consultation

It would seem that Mr. Dare had anticipated almost every contingency. As a matter of fact, the booklet describes the function of a special button called the "C" or consultation button: "When this button is pushed, and generally this would only happen in a case of the patient's questioning the technique used by the machine, the library portion of the machine will immediately provide the patient-operator with back issues

of popular magazines and newspapers having articles of medical importance where an alternate technique might be described."

Kinescopes of medical TV programs are also available on the deluxe model, according to Mr. Dare.

"These are projected on a screen," he said, "where the patient-operator can review the technique used for various operations without getting off the table himself. However, this file is not yet complete since TV has not yet been able to get to all the operations which the Dare Automatic Home Surgeon is capable of performing."

"You might wonder," asked Dare, "can anyone use this machine? The answer is NO. Children should not be allowed to use this machine at any time . . . even in play," emphasized the inventor and humanitarian.

Mr. Dare said his machine will be available on a rental basis as well as outright purchase. "Many families will not be able to afford the initial cost, roughly \$112,000. However, I hope to arrange purchases on the installment plan.

Competition

"Surgeons," he assured us, "need not be afraid of the competition of a do-it-yourself surgery machine since the machine was designed for poor people who cannot afford the surgeon's standard fee."

Not content to rest upon the laurels of this magnificent adventure, as what really great man ever

is, Dare told us he's not through yet. He has another machine in progress, a machine for diagnosis.

"This new invention," according to the inventor, "will enable every home to have its own Home Diagnostic Machine. Every mother, every father, in fact every person alive may, with the new Diagnostic Machine, successfully determine what ails him. I feel, with the advent of this machine that any person when asked 'How do you feel?' should be able to answer in complete medical detail . . . no more insipid replies such as 'fine, I guess,' or 'OK,' or 'I think I'm coming down with something'."

We decided we'd strike a strong blow in defense of private practice. "What of private practice?" we said stoutly.

"I know what you mean—you're worried. Well, although physicians the world over may feel that this diagnostic machine will cut into their medical practice," Mr. Dare said feelingly, "this is a ridiculous assumption! And do you know why it's ridiculous?"

"No," we said honestly.

"The patient may diagnose himself but never will he be able to treat himself—because I'm not going to invent any treatment machine. It's entirely too dangerous."

By this time, we felt we knew Mr. Dare well enough to begin edging him toward the door. Now that we were waking up we remembered some work needed doing on the next issue of your journal as well as the

exhibit at the A.M.A. Convention in New York City.

"Do you plan to exhibit at the A.M.A. Convention next month?" we asked as we rose to our feet.

No rush

"Maybe next year. They don't seem to feel the machine is ready, yet. Actually, I'm in no rush. I'm certain when the machine catches the attention of a few medical men, it'll sweep the country in no time at all."

"Well, we sure do thank you for taking the time to come in and tell us about it," we offered hesitantly.

"Not at all. You people reach the most important young group of medical and surgical men in America and I felt you ought to let your readers know."

Well, now you know. Any of you considering changing your specialty into something not covered by Mr. Dare's invention is welcome to write us a note. We'll be happy to send you a list of sub-sub-specialties not handled by the American Home Surgeon.

Incidentally, Mr. Dare welcomes all surgeons to visit him and try out his machine in Alaska. As he puts it, "I cordially invite any resident physician to come and see this machine in operation. Please bring your own patients because, as I said, mine are pretty well used up . . . er . . . taken care of now." And for any resident who intends to switch out of surgery and into psychiatry, we might as well tell you right now

Resident Physician

that we
Mr. M.
he has
it-your
Maybe
give a

that we just received a letter from a Mr. M. Fuhl Hardy who informs us he has recently perfected a new do-it-yourself psychoanalysis machine. Maybe we'll invite him in one day to give a full report. It sounds inter-

esting . . . and yet, he claims it still has a few bugs. . . .

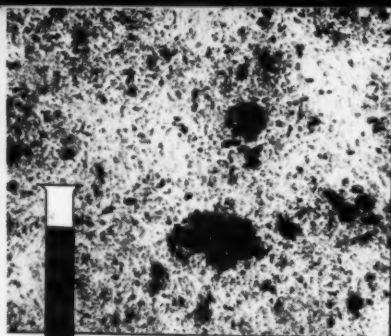
Well, if you'd like to hear more about it, just let us know.

And if you wouldn't, don't write.

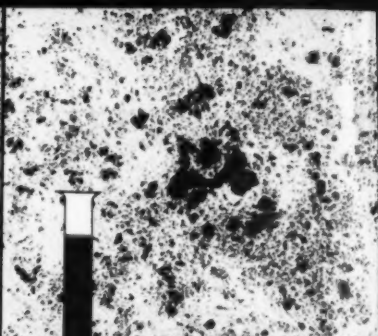
We'll understand.



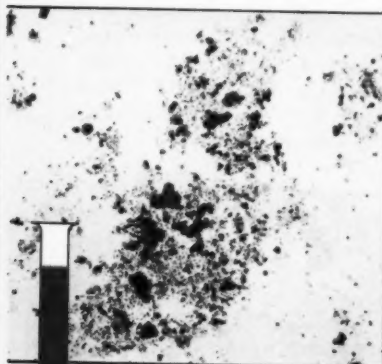
"He's not very bright, but what a surgical assistant!"



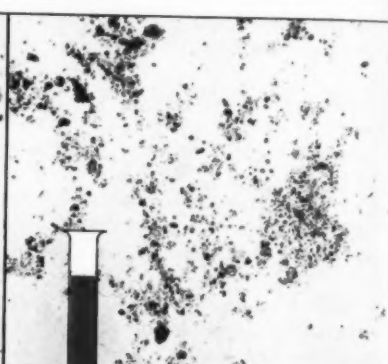
First day, before administration of Zanchol.



Second day, after Zanchol administration



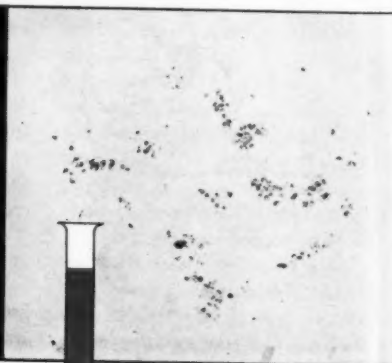
Third day.



Fourth day.

photomicrographs¹

showing daily changes in sediment from centrifuged bile taken from T-tube drainage in a postcholecystectomized patient.



Fifth day.

Z

This
velop
synth
macro

ZA

- inc
- dec
- imp
- bri
- red
- evi
- inc
- of

Indi
chr
are
pos

NEW SEARLE RESEARCH PRODUCT

Biliary Abstergent and Hydrocholeretic
SC-1674, Now Available as...

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(brand of florantyrone)

This newest Searle Research development is a chemically distinct synthetic agent with unique pharmacologic and clinical properties.

ZANCHOL

- increases volume of bile
- decreases viscosity of bile
- improves color of bile to a clear, brilliant green
- reduces bile sediment and opacity, as evidenced in T-tube patients
- increases abstergent cleansing action of the bile

Indications: Zanchol is indicated in chronic cholecystitis patients who are not treated surgically; also in postcholecystectomy patients with

T-tube drainage, and in prophylaxis and treatment of the "postcholecystectomy syndrome."

Dosage: Dosage will vary with each patient's requirement. However, most patients will respond satisfactorily to a daily dosage of three to four tablets with meals and at bedtime.

Supplied: Zanchol is available as uncoated tablets of 250 mg. each, bottles of 100 and 1,000.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

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SEARLE



Allergy Accidental Death And the Law

If the physician is not negligent, a rare result from an accepted and ordinary medical treatment does not in itself expose him to malpractice judgment.

George A. Friedman M.D., LL.B.

The protective response from repeated exposure to a foreign substance is termed allergy. The word is derived from the Greek *allos* and *ergia* meaning altered reactivity. Ten percent of the people of the United States show evidence of the major allergies at present. The percentage is constantly increasing due in part to the introduction of new products and the greater understanding of the disease.

During the U. S. Civil War, a dentist extracted a tooth from Mr.

Bogle who had previously been thrown from his wagon by a horse. He was rendered unconscious, became ill, but then subsequently recovered. Chloroform was used for the extraction which at first stimulated the patient but then when greater quantities were used relaxed him enough for the procedure. The next day the patient complained of numbness in his legs and side following which he became paralyzed. The judge in his charge to the jury said: "There is a great

variety of temperaments among men, upon which, as we learn in the scientific books in evidence, chloroform produces very different effects. If we were to traverse the whole circle of mankind, we might possibly find, even among healthy men, some one who could be paralyzed by its influence, or if not, still among the numerous diseases with which man is afflicted there may occur peculiar conditions of the system in which chloroform may tend to paralysis."¹

The court added that the dentist could not reasonably anticipate that there was a greater danger in this patient's case than that of other patients and the verdict in this malpractice case was against Mr. Bogle. This decision is typical of the judicial treatment of cases involving rare results from accepted and ordinary medical treatment. Thus to recover in malpractice there must be allegation—proof of an additional act of negligence on the part of the doctor.

In a Texas case decided last year² the mother asserted that she had warned the physician of her daughter's allergy prior to the operation which eventually resulted in the daughter's death. But since the mother failed in her proof of prior warning of the hypersensitivity manifested during a previous tonsillectomy which was almost fatal, she was denied recovery.

Injury

In 1955 the patient sued for in-

juries she alleged resulted from spinal anesthesia administered her during the delivery of her child, alleging in the malpractice action that her spinal cord had been injured. Testimony by the anesthetist ascribed the injury to the sensitivity of the patient to the drug. The court held that there was no evidence of negligence and cited the administration of a spinal block in a prior delivery without adverse results. The court said: "In the instant case, an inference may be drawn from substantial evidence in the record that the injury was not caused by negligence but by some condition existing in the patient's system."³

Where a spinal anesthetic had been administered prior to an operation⁴ and permanent injury resulted to the nerve endings with paralysis and atrophy, the court said: "We think it is beyond dispute that the nerve roots which were damaged in the process of producing anesthesia by injecting the drug into the spinal cord are within the region of treatment and that the cause of this injury to the nerve roots and its effect on the leg and adjacent organs must be explained by experts. Where the expert testimony offered by the plaintiff ascribes the cause to the toxic quality of the injected drug as distinguished from the negligence of the anesthetist, that evidence is binding upon the court and the jury would not be permitted to

speculate to the contrary.”⁵

Varying conditions

After an injection of novocaine during a circumcision⁶ the plaintiff asserted that he had been injured. The court in establishing that this was insufficient to show malpractice, declared: “Practical application of medical science is necessarily to a large degree experimental. Due to the varying conditions of human systems the result of the use of any medicine cannot be predicted with any degree of certainty. What is beneficial to many sometimes proves highly injurious to another. The rag-weed is a thing of beauty to one person; to another it is a thing to be shunned. Even the expert cannot completely fathom or understand the reactions of the human system.”

The plaintiff and her friend⁷ went to defendant's clinic to receive his ophthalmological treatment for cataracts. He injected a solution into their eyes to stimulate the circulation. However, the plaintiff had a reaction, greater than anticipated, and at the time of trial suffered from chronic inflammation. She recovered judgment in the trial court but this was reversed since medical testimony indicated that the infection was but an extension of an already existing infection or from her supersensitivity to the drug. Her evidence at the time of the trial failed to establish any negligence on the part of the defendants.

Following an appendectomy, while the patient was unconscious, one of defendant hospital's nurses injected a saline solution into the plaintiff's breasts. The nurse noted that the solution was not flowing properly but she continued the infusion. As a result the plaintiff became ill, her breasts became scarred. The hospital asserted in defense that plaintiff's reaction was caused by an idiosyncrasy but the court said that this fact had been passed on by the jury. Just because she was more susceptible to injury than an ordinary person does not mean she will be denied recovery, said the court. Judgment for the plaintiff was affirmed.

Plaintiff had been tested for allergies at a hospital and found allergic to mercury. After a few months, plaintiff's wife took a prescription for a lotion to a druggist. However, when the druggist filled the prescription he substituted mercury. After the first application a rash appeared and plaintiff's doctor called the druggist and asked him whether there was any mercury in the preparation. Upon being assured there was none present the physician told the plaintiff to apply it more liberally to the surface of the skin. He did this and was severely injured, being unable to wear clothes for some two months. It was held that the druggist was liable in negligence for the misrepresentation he made to the plaintiff and to the physician

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To those who already own the famous Model 51 Viso-Cardiette, the new VISETTE can be an invaluable "companion" ECG — especially suited to use outside the office, or in hospital wards. Or, for those who prefer a larger instrument, using conventional 6 cm. width recording paper, the "51" is still available at \$785 delivered.



and the plaintiff was granted a new trial.⁸

Penicillin

During 1953 some 350 tons of penicillin were distributed in the United States. In the two year period leading up to that date the Food and Drug Administration surveyed the reactions to the antibiotic. There were 57 reported cases of penicillin anaphylaxis of which 18 were fatal.⁹ It was but four years before this that the first fatal anaphylactic reaction to penicillin had been described.¹⁰

A report was presented to the American Academy of Forensic Sciences in 1952¹¹ of two autopsies performed on two fatal cases of anaphylaxis following intramuscular injection in patients with long standing histories of bronchial asthma (Greek: panting). They concluded that considerable care should be exercised in administering any of the antibiotics to patients who are likely to be hypersensitive. For persons with allergic diathesis the antibiotics should be the last rather than the first remedies chosen.

As the knowledge of allergic reactions to certain drugs increases, the standard of care expected of the physician will be modified. At present there is broad clamor for the avoidance of needless exposure to penicillin to avoid sensitization.¹¹ Further it is incumbent upon the physician to take a careful history to exclude allergy and to do a pre-

liminary skin testing procedure as an additional precaution. He may have to modify his ordinary technique in a given case.

The physician in a malpractice case will be required to know all the recent developments in the field which are generally known by other members of his profession. The doctor should be in the diagnostic position to anticipate the possibility of an allergic reaction.

Insurance

Insurance companies are involved in litigation concerning their "accident" policies. Also they are sued on indemnity clauses involving death from "external, violent or accidental death" and not from disease.¹²

What is accidental? One view is that the event or act which produced the injury must have been unexpected or unanticipated.

The other view is that the term does not necessarily require a slip, mischance or anything out of the ordinary in the act by the insured which leads to the injury. It is enough that the injury or death be an unexpected, unusual or unforeseen result.¹³

A suit¹⁴ was brought by the beneficiary following decedent's death caused by hypersusceptibility to an anesthetic during a major operation. Rejecting a claim of accidental death the court said: "All the physicians testified that such result was exceedingly rare, occurring perhaps once in a hundred thousand administrations; that the reason why

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Each one-dose vial (to be reconstituted with 2 cc. distilled water) contains:

TETREX (tetracycline phosphate complex)	100 mg.
Xylocaine hydrochloride	40 mg.
Plus ascorbic acid and magnesium chloride as buffering agents.	

TETREX is the clinically "sodium-free" tetracycline — devoid of potential hazard in the treatment of patients on restricted sodium intake. With only one atom of sodium in its chemical formula, TETREX contains but an infinitesimal amount of sodium — which may actually be so bound that it cannot be released in the body at all.

Other useful TETREX forms:

TETREXTM Capsules
tetracycline phosphate complex, each capsule containing the equivalent of 250 mg. tetracycline HCl activity.

TETREXTM SYRUP
tetracycline (phosphate buffered) syrup, each teaspoonful (5 cc.) containing the equivalent of 125 mg. tetracycline HCl activity.

TETREXTM Pediatric Drops
tetracycline (phosphate buffered) syrup, each cc. containing the equivalent of 100 mg. tetracycline HCl activity.

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IS ADEQUATE FOR ALL REQUISITIONS**



it ever occurred was unknown; and that death was due to hypersusceptibility of the particular individual to the particular anesthetic."¹⁵

Butyn was administered prior to an examination and the patient died. Suit was brought on the policy. It was held that death resulted from medical treatment and not by accident. Although death was unexpected because of decedent's idiosyncrasy, it was still part of the medical treatment given to him.¹⁶

The opposite view is reflected in this case.¹⁷ The patient, a physician, was given Novocaine as he was being prepared for an operation. Because of his hypersusceptibility he died. Suit was brought by his beneficiary under the insurance policy for payment of double indemnity for death by accidental means. Since the idiosyncrasy was not discoverable prior to the injection said the court, and since the result was accidental although the intent to have the injection was deliberate, recovery was granted. The court here said that death was by "accidental means" and it is sufficient that the result of an act is "unusual and unforeseen." Also idiosyncrasy is not a bodily infirmity within any exclusion of the policy. Allergy should not be determined as a "disease or bodily infirmity" within the meaning of the exclusion.

The insured went to her doctor's office for a tonsillectomy and after having been injected with Nupercaine died during the operation.

After the physician testified that her death had resulted from hypersensitivity to the drug which could not be determined beforehand, the court held that this was accidental death within the terms of the policy.¹⁸ Similarly the administration of Novocaine prior to a tonsillectomy¹⁹ or appendectomy²⁰ has led to the same result, i.e., death due to hypersensitivity called an "accident" and covered by the policy.

In a 1954 case the decedent had a tonsillectomy and Neohemoplastin, a blood coagulant, was administered. An allergic reaction ensued followed by death. Suit was brought on the insurance policy for double indemnity. The court said: "This hypersensitivity of the insured was unknown and unsuspected at the time of the administration of the drug. The result was entirely unforeseen and unexpected. While the hypersensitivity may have been determined by tests, I find that the drug has been used by doctors for many years in the treatment of many thousands of patients without ill effects. It had so been used by the attending physician about 100 times. The drug was made by a responsible concern. I find, if material, that there was no negligence in failing to test the insured or in ordering the administration of the drug. The plaintiff concedes that the doctor was not guilty of negligence, and I find that what was done was normal and proper procedure.

The court then discussed the split

of authorities as to "accident" in insurance policies and held that the law of the state governing the insurance contract applied and would not permit recovery.²¹

Workmen's compensation

Claimant²² while working next to a suction fan had been exposed to great amounts of cold air, chemical vapors, dust and paint fumes which had been suctioned past him. He contracted bronchial asthma and sustained double hernia from the severe coughing spells due to the asthmatic bouts. He had never had asthma but was constitutionally predisposed towards it from childhood. The court held that this was "accidental" within the meaning of the statute. In construing "accident" the court interpreted event as not necessarily meaning a single happening. Also they decided that "sudden" does not necessarily mean instantaneous. The court will allow recovery normally so long as the injury is unforeseen or unexpectedly received.

A case of bronchial asthma suffered by a New York claimant was held to be a compensable occupational disease.²³

Where any reasonable relation to the employment exists, or the employment is a contributory cause the court is justified in upholding the award. It is quite likely that the courts will continue to compensate allergic workmen who are disabled just as much as normal persons

would be compensated. The following were held responsible: masseur allergic to alcohol; bankteller allergic to money; and a janitor allergic to dust.

Consumer

The majority of reactions from cosmetics are individual ones and are due rather to the allergy of the affected person than to the harmfulness of the cosmetic.²⁴

Repeated outbreaks of cosmetic dermatitis have been due to preparations used on the hair, the nails and the lips. Especially with the use of hair preparations there should be testing for sensitivity prior to their use. Some of the ordinary cosmetics contain from fifteen to fifty ingredients. At present two thousand ingredients are being researched at the Laboratory of Applied Physiology at Yale University relative to sensitization and irritation arising from cosmetics.

A plaintiff sued for dermatitis she contracted as the result of the dyes in a dress she had purchased. She lost. The vendor was held not liable for the breach of an implied warranty solely because of the buyer's individual idiosyncrasy.²⁵

An allergic reaction to ordinary allergy-producing foods such as eggs, strawberries, fish is not legally compensable. It is the relationship of the injury to the product²⁶ which presents an insuperable obstacle to the food-allergy plaintiff. The plaintiff must establish that this particu-

lar food caused the harm. Food processors would be unnecessarily restricted were it necessary to be liable in damages for allergic reac-

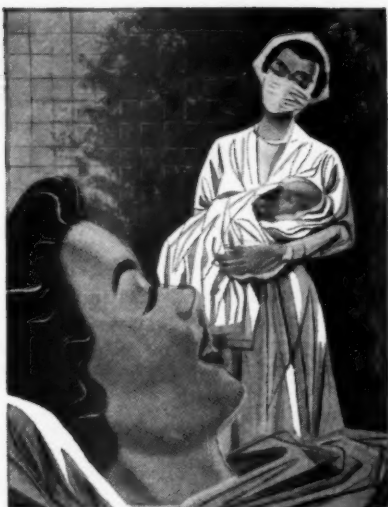
tions to a very small percentage of the population. Thus civil liability for allergy is now not imposed in warranty.

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WASHINGTON REPORT

Current news items of special interest to residents and reserve medical officers, reported directly to your journal by the Army, Navy, Air Force, Veterans Administration and the Public Health Service:

RESERVE SEMINAR . . .

A series of special scientific and technical seminars, beginning in July, will be offered scientific and technical Reserve officers of the Air Force, Army and Navy, not on active duty. Seminars will meet the requirement for 14 days active duty training for Reserve personnel and are designed to provide officers with a knowledge of research programs in the armed services and interest them in current problems in research and development.

Not all of the seminars have direct application for the average physician, but each will have medical aspects. The five seminars announced so far, with opening dates, are as follows:

● *Nuclear Science.* Idaho Falls, Idaho, to convene July 22, 1957. Seminar leaders and speakers will represent the Idaho Operations Office of the Atomic Energy Commission, the staffs of contractors at

the National Reactor Test Site, Arco, Idaho; the Office of Naval Research; and the staff of the Commandant, 13th Naval District.

● *Nuclear Science.* Brookhaven National Laboratory, Upton, New York, to convene September 9, 1957. Seminar leaders and speakers will represent the Brookhaven National Laboratory; the Office of Naval Research; and the staff of the Commandant, Third Naval District.

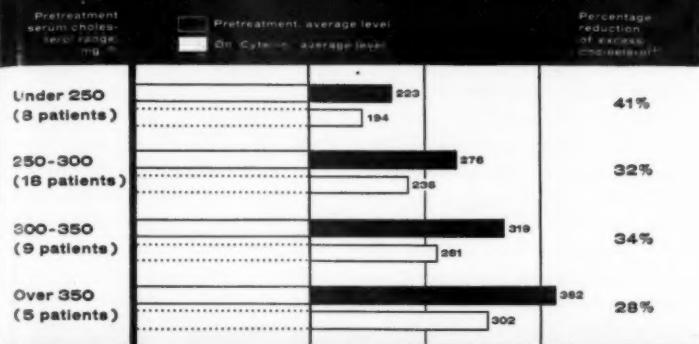
● *Nuclear Science.* Oak Ridge, Tennessee, to convene November 25, 1957. Seminar leaders will represent the Atomic Energy Commission facilities at Oak Ridge.

● *Aviation Medicine.* USN School of Aviation Medicine, Pensacola, Florida, to convene May 12, 1958.

● *Research.* Office of Naval Research, Washington, D. C., to convene June 16, 1958.

Those attending these seminars must have secret clearance and be certified by the cognizant command.

EFFECTS OF CYTELLIN ON SERUM CHOLESTEROL



Serum cholesterol, mg. 150 350 350

*Adapted from *Am. J. Med.*, 1957, 23, 100-101.
 by J. M. S. 1957, 23, 100-101.
 and Company, Inc. 1957.

*Although a "normal" serum cholesterol level has not been established, a concentration of 150 mg. percent probably approximates the "ideal" level. Concentrations above this are considered excess.

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reduces elevated serum cholesterol

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'Cytellin' reduces the absorption of dietary cholesterol and the reabsorption of endogenous cholesterol excreted in the bile. Severe dietary restrictions are not necessary to obtain a significant decline in serum cholesterol level. For a majority of patients, 'Cytellin' provides the most rational and practical therapy available.

In addition to lowering hypercholesteremia, 'Cytellin' has been reported to effect reductions in C/P ratio, Sr10-100 lipoproteins, and beta lipoproteins.

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Air Force

NEW TEACHING HOSPITAL . . .

Some 25 physicians begin residency training and 23 others begin one-year rotating internships, July 1, 1957, at the new Lackland Air Force Hospital, San Antonio, Texas. The new 500-bed teaching hospital offers residency training in general surgery, orthopedic surgery, general practice, anesthesiology, pathology, radiology, and internal medicine. The modern, nine-story building (see photo) is designated an Air Force Specialty Treatment Center and is affiliated with the University of Texas Medical Branch. The teaching staff includes both civilian and military physicians. Patients are Air Force personnel and their dependents from approximately 15 Air Force installations in the southwestern United States.

RESIDENCY REPORT . . .

The Air Force intends to limit to 250 the number of 1957 graduates of

medical school accepted for deferment under the Berry Plan. These will be selected according to specialties in demand by the Air Force at the present time. Currently needed specialists are in the fields of general practice, otolaryngology, psychiatry, pathology, ob-gyn, preventive medicine, industrial medicine, physical medicine, and neurology.

In July, the Air Force will receive for active duty its first group of fully trained specialists who had been deferred for residency training under the Berry Plan in specialties having a two-year minimum training requirement. Civilian training hospitals, the Air Force and individual physicians who participated (and were thus able to complete their residencies without interruption for military service) have, according to Air Force report, found the program to be mutually beneficial. However, the full value of the program to the Air Force is not



New Air Force Teaching Hospital at Lackland Air Force Base, Texas.



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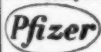
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expected to be realized until 1958-59 when the three- and four-year residents complete their training.

As of July, the Air Force will have 593 physicians in deferment in all specialties.

Berry Plan

NEW INTERNS . . .

Since the inception of the Berry Plan, your editor has exhorted students in his medical school and interns on his service to have their minds made up about certain things which have to do with their obligated military service so that they can cope promptly with the Berry Plan when information concerning it arrives in their hands about the middle of July. Thinking should be completed and decisions should be made by that time on the following points:

- Which branch of service . . . Army, Navy, or Air Force? Interns should remember that reserve commissions are also obtainable in the Commissioned Corps of the Public Health Service, and that your draft obligation can be fulfilled with that Department. (The Public Health Service is separate from the Department of Defense program and not a part of the Berry Plan.

To participate in the Department of Defense program (Berry Plan) you must be willing to accept a commission in the Army, Navy, or Air Force.

- Do you want to be deferred for residency training? If so, what

type of residency training do you want? If you are deferred for a specialty, *you cannot change your mind and ask for another specialty.* In other words, no switches are allowed after you have gained a deferment for residency training in a specialty. It is also important to remember that, by and large, and provided no emergency occurs, the military service for which you have been deferred expects you to complete your residency training program before entering on active duty.

- *Do not apply for residency training* in subjects not listed in the *Information Bulletin*, which you will receive early in July.

- If you do not want to be deferred, actions to be taken are clearly indicated in the *Information Bulletin*.

- The following dates are important in the 1957-58 program:

September 15, 1957. Deadline for return of "Statement of Preference" (SD Form 249).

December 1, 1957. Deadline for submitting application for commission in the service of allocation.

March 1, 1958. Deadline for obtaining residency and sub-

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is the patient for whom you prescribe**

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1. Johnson, H. J., Jr.: *Am. Pract. & Digest.*
Treat. 5:862 (Nov.) 1954.
2. Beale, H. D.; Rawling, F. F. A., and
Figley, K. D.: *J. Allergy* 25:521 (Nov.) 1954.

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mission of "Hospital Agreement" (SD Form 248), and "Request for Deferment for Residency Training" (SD Form 247).

● Correspondence concerning your assignment, the status of your

application for a commission, and time of call to active duty should be addressed to the military department to which you have been allocated. For example: The Surgeon General, Department of the Army, Washington 25, D. C.

Army

ORIENTATION COURSE . . .

The Army Medical Corps Orientation Course for physicians ordered to extended active duty is designed to provide basic military training and an introduction to military medicine for newly commissioned Army Medical Corps officers.

Classes begin on Monday following the reporting date, continuing for five weeks. Training is concluded with a graduation ceremony on Friday morning of the final week, and student officers are usually free to depart by noon of that day. The few days between the reporting date and the start of classes are required for purchase of uniforms and equipment, immunization and blood-typing, preparation of military records, class organization, assignment interviews, and dissemination of introductory material designed to aid in the transition from civilian to military life.

The course is given at the Army Medical Service School, a unit of Brooke Army Medical Center, located at Fort Sam Houston, Texas.

The post is situated entirely within the metropolitan area of San Antonio, in the northeast section of the city.

Travel

Pay and allowances of Army Reservists begins on the day they officially and necessarily begin to comply with orders calling them to active duty. (The term "necessarily begin to comply with orders" means that for pay purposes compliance may not begin earlier than the day necessary for the member to arrive at his station on the day he is required to report). When travel time is computed for the purpose of determining active duty pay and allowances, the *day of reporting* is considered a *day of travel*. Travel time, therefore is:

● When travel is by common carrier (train, bus, air) the actual time used but not to exceed normal transportation schedule time.

● When travel is by private auto, 300 miles per day and 1 day for any fraction over 150 miles.

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When authorized travel time is exceeded, the days exceeded will be considered active duty time *without* pay. For example: Officer has effective date for active duty (EDSCA) indicated in orders as 1 April and to report NLT (not later than) 6 April. He departs home 1 April and arrives 3 April by commercial air. His first day of pay is 3 April since travel time by air is 0 days and day of arrival is counted as a day of travel. Officer should have arrived on 1 April based on travel time of commercial air. Another officer has orders showing effective date of active duty (EDCSA) is 2 July and reporting NLT (not later than) 7 July. He departs home 2 July by private auto and the distance to his reporting station is 1200 miles. He visits friends on the way and reports for duty on 7 July. His first day of pay and allowance is 4 July, since his authorized travel times was four days and he exceeded this time by two days.

Officers may travel at their own expense and receive the prescribed mileage allowance after the travel is completed, or they may travel at Government expense by presenting copies of orders to a Military Transportation Officer and securing a Transportation Request exchangeable for tickets on commercial carriers. In the latter case, a money allowance for each day of travel and reimbursement for certain incidental expenses is also payable on completion of the travel upon

presentation of the memorandum copy of the Transportation Request. Definite information on which to base a choice of these options for commercial travel can be obtained from a Military Transportation Office.

If arrival in San Antonio is at an air, rail, or bus terminal, further transportation to Fort Sam Houston should be readily available by commercial taxi or bus service. If commercial transportation is not available and Government transportation is required, it may be requested by calling the Adjutant's Office of the School, telephone CA 2-8411, extension 2513.

Delay

If it becomes impossible for an officer to comply with orders, he is advised to contact the agency issuing the orders. If an emergency situation arises while en route to Fort Sam Houston, he should contact the Adjutant, Army Medical Service School.

Reporting

The four main buildings of the School are located in a "quadrangle" area on Stanley Road, between the Post Theater and the Main Post Exchange. The Headquarters building, facing Stanley Road, is designated as "DeWitt Hall," and the other three (clockwise) "Wickert Hall," "Coers Hall," and "Blesse Hall."

Formal reporting is not required. Neither is it mandatory to be in uni-

form upon arrival. To facilitate in-processing and billeting, officers are encouraged to arrive on the post during normal duty hours, if orders permit, and report to the Officer Student Detachment, West Basement, Sec. IV, Coers Hall. If arriving after duty hours on week-days, or on a holiday or a week-end, officers may report to the Adjutant's Office, Room 108, Section II, DeWitt Hall.

Uniforms

Officers who do not have uniforms are advised to defer their purchase until after reporting; detailed information on items required and complete selections at either the Quartermaster Sales store or civilian stores in San Antonio will be available. The winter uniform, shade 51 coat and shade 54 trousers, commonly referred to as "pinks and greens," with the visored service cap for male officers, and the wool taupe suit for female officers are prescribed for general duty wear between 1 December and 15 March. The summer duty uniform, shirt and trousers of cotton khaki or other suitable material with the garrison (overseas) cap for male officers, and the summer cotton dress taupe uniform for female officers are prescribed from 15 March through 30 November. Field clothing required for the Course may be purchased after arrival.

Civilian clothing may be worn when off duty.

Finance

From three to four weeks are required to complete processing of uniform allowance and travel payments for officers entering on extended active duty. For this reason these officers are advised to have available sufficient funds to purchase initial uniform requirements (about \$100) and to defray living expenses during that period. Payment of basic active duty pay and allowances is normally made on the last day of the month.

Officers on short tours of active duty for training are paid in cash on the last day of the course for round-trip travel and all pay and allowances for the entire period specified in their orders. Officers on temporary duty from other stations are normally paid by their home stations.

Personal checks not exceeding \$50 in any one day may be cashed at the Main Post Exchange.

Military Records

Officers ordered to extended active duty should bring with them copies of active duty orders and amendments, telegrams received in lieu of orders or in connection therewith, letters of appointment as commissioned officers, records of prior service, correspondence pertaining to reserve participation and any other documents in the officer's possession dealing with the individual's military status. While it is probable that some of those papers will not be

required, it has been found that many problems on service credit and status can be avoided by having complete reference material available.

Dependents' Travel

There is no military objection to having dependents accompany student officers to San Antonio although travel allowance in their behalf does not accrue on the basis of initial orders alone since assignment to the school is for "temporary duty pending further orders." Officers may live off the post with their families, but must make personal arrangements to commute between their residences and the school.

Housing

Living quarters, referred to in the service as Bachelor Officer Quarters, are available on the post for student officers. Government family quarters are not available; however, civilian rental properties in San Antonio are considered in adequate supply, although there may be some limitation on selection because of the length of occupancy anticipated. Rental prices are believed to compare with average rentals in cities of similar size throughout the United States. Since San Antonio is a tourist mecca, there are many motels and tourist courts. Regarding these accommodations, locations on either Broadway or the Austin Highway or vicinity are especially convenient for personnel on duty at Fort Sam Houston.

Because of the number of student officers arriving at this station periodically and the substantial personnel turnover at the school and throughout the post, it is not possible for military agencies to publish more detailed rental housing information such as property listings, or to attempt to make advance reservations for officers seeking family quarters. After arrival, the Billing Office at Post Headquarters, Building T-300, may be contacted for assistance in obtaining civilian living accommodations.

Rental Allowance

In addition to the regular pay, married officers or single officers with legal dependents receive a rental allowance, payable regardless of the location of the dependents, so long as they are not occupying Government quarters. The officer's occupancy of Bachelor Officer Quarters does not affect his entitlement to the dependent rental allowance.

Household Goods

Because of the temporary nature of initial assignment there are certain restrictions on packing, storage, and shipment of household goods in connection with duty at Fort Sam Houston. (Upon assignment to a permanent station, officers will become entitled to these services as authorized by appropriate regulations. Complete instructions will be furnished after new permanent change of station orders are received.

Officers whose entry on active duty will necessitate immediate movement or storage of household goods are advised to contact their nearest Military Transportation Officer or to write The Commanding General, Fort Sam Houston, Texas, Attention: Transportation Officer, for further information.

Within a few days after reporting, officers will have an opportunity to express their preferences for location and type of duty assignment to follow the period of training at the school. Insofar as possible, individual preferences are considered, although the needs of the service remain paramount. Reassignment orders are issued by the Department of the Army on request of the Office of the Surgeon General, and no advance information regarding definite assignments is available at the Army Medical Service School. Male officers may be assigned to any military station or activity within the United States or overseas, while initial assignment of female officers is ordinarily limited to the U. S. Orders are usually received about ten days before the end of the course.

Leave

Leave is accrued at the rate of $2\frac{1}{2}$ days per month. Granting of leave that would involve absence from classes during the period of the course is limited to emergency or compassionate cases. Upon completion of training, reassignment orders for extended active duty officers in most cases provide for a minimum of three days leave if the new assignment is in the States and seven days if overseas service is involved. This leave is in addition to the prescribed travel time authorized between Fort Sam Houston and the new station or port of embarkation.

Communications

If it becomes necessary to contact the school, communications should be addressed to:

Commandant

Army Medical Service School
Brooke Army Medical Center
Fort Sam Houston, Texas

Attention: The Adjutant

Telephone: San Antonio—Capitol
2-8411, Extension 2513 (Office of the Adjutant).



Licensure for Foreign Graduates

*in Delaware, Florida and
District of Columbia*

DELAWARE

An applicant for a license to practice medicine in Delaware must fulfill the following requirements:

- Be over 21 years of age and of good moral character.
- Be a full citizen of the United States.
- Obtain a degree from an American medical college acceptable to the Medical Council of Delaware.
- Serve one year as an intern in an American hospital acceptable to the Medical Council.
- Reside in the state for at least one year.

Exceptions to the above qualifications may only be made on unanimous vote of the Medical Council.

DISTRICT OF COLUMBIA

An applicant for licensure in the District of Columbia must:

- Be not less than 21 years of age and of good moral character.
- Have at least two years of pre-professional education and training in a college or university acceptable to the District Commission on Licensure before commencing the study of medicine.
- Be a graduate of a medical school included in the list of foreign medical schools prepared by the Council on Medical Education and Hospitals, American Medical Association and the Executive Council of the Association of American Medical Colleges.
- Show satisfactory proof that he

has completed or is about to complete one year of training in a Class "A" American or approved Canadian hospital.

EXAMINATION. All credentials submitted with an application for license to practice medicine and surgery by examination in the District of Columbia are subject to evaluation by the Commission. The Commission on Licensure has the authority to reject any or all credentials not meeting the prescribed standard. Formal application must be accompanied by:

1. Original medical school diploma.
2. Original intern certificate.
3. Photograph, postcard size.
4. Application fee of \$25.

All applicants who were graduated from approved foreign medical schools are required to submit in addition to the four (4) items listed just above:

- One photostatic copy of medical school diploma and a certified translation (if in a foreign language).
- A basic science examination is required.

Applicants seeking exemption from the basic science part of the District of Columbia examination by

virtue of having passed a basic science examination before another examining board are, in addition to the items listed above, required to submit:

- (a) Certified list of grades in the basic science subjects.
- (b) Basic science questions (and answers, if available).
- (c) Letter addressed to the District of Columbia Basic Science Examining Board requesting exemption.

(Note: The Commission will procure items (a) and (b) from the National Board of Medical Examiners for applicants seeking exemption from the basic science part of the District of Columbia examination by virtue of having passed the first part of the National Board Examination.)

The Basic Science Examining Board meets early in April and October each year to consider requests for exemption. These requests are not passed on automatically by the Basic Science Examining Board but are considered individually on their merits on the basis of the evidence available as to the adequacy of the previous basic science examination and its results.

Each state of the United States has established its own regulations for licensing physicians. For the U. S. medical school graduate, rules are much the same from state to state. But for the graduate of a foreign medical school, there are important differences.

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ENDORSEMENT. A diplomate of the National Board of Medical Examiners is eligible to apply for a license on the basis of his National Board Diploma. The Diplomate's pre-professional education and training, professional education and training and hospital internship are subject to evaluation by the Commission.

Formal application must be accompanied by:

1. Original medical school diploma.
2. Original intern certificate.
3. Photograph, postcard size.
4. Application fee of \$25.

All applicants who were graduated from approved foreign medical schools and interned in foreign hospitals are required to submit in addition to the four items listed above:

(a) One photostatic copy of medical school diploma.

(b) One photostatic copy of intern certificate.

(c) One certified translation of items 1 and 2 (if in a foreign language).

All applicants who were graduated from foreign medical schools not on the list prepared by the Council on Medical Education and Hospitals, American Medical Association and the Executive Council of the Association of American Medical Colleges are required to submit in addition to formal application, photograph and fee, the following:

- Original medical school diploma and two photostatic copies.

- Original transcript of record from medical school (listing subjects, grades, etc.) and two photostatic copies.

- Original intern certificate and two photostatic copies.

- Two (2) certified translations of items 1, 2 and 3 just above, if in a foreign language.

Upon receipt of formal application and proper supporting data, the Commission will procure the Diplomate's grades (and questions) from the National Board and submit them to the D.C. Basic Science and Medical Examining Boards for consideration and report. In order to be eligible for license on this basis, the examination taken before the National Board must have been as comprehensive and exhaustive as that required in the District of Columbia.

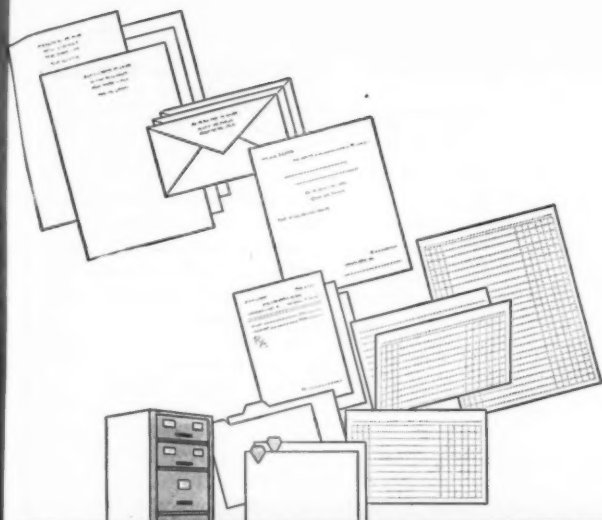
Applications may be submitted at any time and the applicant is notified in writing when action has been taken on his application. Every application is considered individually and on its merits.

RECIPROCITY. Every applicant for a reciprocal license to practice medicine and surgery in the District of Columbia shall:

- Be not less than 21 years of age and of good moral character.

- Have a license to practice medicine and surgery obtained under conditions that at that time would have enabled him to have qualified for a license to practice medicine and surgery in the District of Columbia. (The license used as a basis

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for reciprocity must have been obtained by regular written examination.)

● Submit proof of practice of medicine and surgery after the issuance of license for not less than one continuous year out of the three years immediately preceding the date of present application. The required year's practice may be either private, institutional, governmental or a combination.

All credentials submitted with an application for license to practice medicine and surgery in the District of Columbia by reciprocity are subject to evaluation by the Commission.

Formal application must be accompanied by a photograph and an application fee of \$50.

All applicants who were graduated from approved foreign medical schools and interned in foreign hospitals are required to submit:

1. One photostatic copy of medical school diploma.
2. One photostatic copy of intern certificate. One certified translation of items 1 and 2 (if in a foreign language).

In addition, all applicants who were graduated from foreign medical schools not on the list prepared by the Council on Medical Education and Hospitals, A.M.A. and the Executive Council of the A.A.M.C. are required to submit in addition to formal application, the same items as required of applicants for licensure by endorsement.

A License to Practice

The entire philosophy of state licensure is to insure the American public the highest possible level of professional competence in medical care. For foreign-born graduates of foreign medical schools, and for American-born graduates of foreign medical schools, the licensure requirements of most states represent a serious obstacle.

In some states it is impossible for the foreign-trained physician to obtain a license. Proud of his own training, the foreign-trained physician is apt to resent this and wrongly conclude that these states prohibit licensure of foreign-trained physicians solely because they are *foreign-born*. (This is not true. American-born physicians trained abroad meet exactly the same exclusion in these states.) However, it is true that certain states make this exclusion because they do not believe they have adequate facilities or criteria at present for examining each foreign-trained physician who wishes to apply for licensure.

For some time there has been a growing effort to establish a uniform medical practice act acceptable to all states. But in the interim, the foreign-trained resident must check individual requirements established by the state in which he desires to practice in order to determine his eligibility for licensure.

It is to make this task a little easier that **RESIDENT PHYSICIAN** presents this series of articles on state licensure requirements.

The Commission usually meets on the second Monday in March, June, September and December to consider reciprocal applications. Reciprocal applications may be submitted at any time but will not be accepted after March 1, June 1, September 1, or December 1 for the meeting for that month. Every application is considered individually and on its merits.

ORAL EXAMINATION. Special oral examinations are conducted on the last Wednesday in February, May, August and November. These examinations are required of *reciprocal applicants coming from states which require an examination of District of Columbia reciprocal applicants.*

Examinations, held in the library of the District of Columbia Medical Society, are oral and the questions to be asked are decided upon by the examiners. Reciprocal applicants required to take the oral examination must submit their applications not later than February 1 (for the March meeting); May 1 (for the June meeting); August 1 (for the September meeting); and November 1 (for the December meeting).

FLORIDA

All applicants must be citizens of the United States. First papers are not acceptable. Citizenship papers must be presented to the Credential

Committee.

Application, to be filed with the secretary of the Board at least 30 days prior to the first day of the examinations, requires two 3x4 photographs; one pasted in the space provided and one unattached.

A certificate from the Florida Basic Science Board is a prerequisite for the examination. Dr. M. W. Emmel, Secretary, Basic Science Board of Examiners, P. O. Box 340, Gainesville, Florida, will furnish information and applications for that examination. While it is necessary to have this certificate before taking the medical examinations it is not necessary to have it before filing application.

Graduates of medical schools in the United States, Canada and certain foreign countries approved by the American Medical Association's Council on Medical Education and Hospitals are accepted for examination. Graduates of unapproved schools are not accepted. Examinations are written in the English language. No oral examinations are given.

The Florida law does not provide for reciprocity or endorsement with any state or board.

Completed applications, with fee, are sent to: Homer L. Pearson, M.D., Secretary, Florida State Board of Medical Examiners, 901 N.W. 17th Street, Miami 36, Florida.

Mediquiz



Questions are from a civil service examination given to candidates for physician appointments in municipal government.

(Answers on page 161)

1. The pain, fever and headache of acute maxillary sinusitis may be best relieved by: (A) penicillin; (B) adequate drainage; (C) aureomycin; (D) autogenous vaccine.

2. The course of "virus" tracheobronchitis will be shortened by treatment with: (A) aerosol penicillin; (B) aureomycin; (C) erythromycin; (D) none of the foregoing.

3. The treatment of choice for infectious hepatitis is: (A) bed rest and diet; (B) methionine; (C) aureomycin; (D) intraheptol.

4. A comatose patient has a clear-cut history and clinical findings indicating a brain tumor in the posterior fossa of the skull. Of the following, the most dangerous diagnostic procedure is: (A) lumbar puncture; (B) vertebral artery angiogram; (C) electroencephalo-

gram; (D) ventriculogram.

5. The primary objective of the procedure known as débridement of an accidental wound is to: (A) remove contaminating bacteria; (B) excise skin and thus promote open drainage of the wound; (C) remove non-viable tissue; (D) permit the immediate closure of the skin wound.

6. A patient complains of low back pain after a fall. There is anaesthesia about the external malleolus and an absent ankle jerk. The most likely diagnosis is: (A) spinal cord tumor; (B) herniated intervertebral disk; (C) sciatica; (D) sacroiliac sprain.

7. A 40-year-old man presents with a spontaneous fracture of the femur, severe anemia, marked weight loss, enlarged liver, mild clinical icterus, multiple vitamin deficiencies and a history of moderate diarrhea for several months. The one of the

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following diagnoses which is most likely, presuming all the above findings relate to a single disorder, is: (A) sprue syndrome; (B) cirrhosis of the liver; (C) pernicious anemia; (D) pellagra.

8. Patients with chronic tophaceous gout: (A) rarely die as a result of their disease; (B) rarely have severe arteriosclerosis; (C) seldom have articular destruction; (D) frequently have related renal disease.

9. The combination of low back pain and urinary retention in a 55 year old man should warrant, in addition to other examinations, the determination of the: (A) alkaline phosphatase; (B) plasma protease; (C) serum amylase; (D) acid phosphatase.

10. An elevated serum calcium concentration often appears in the course of: (A) sarcoidosis; (B) myxedema; (C) hypoparathyroidism; (D) uremia due to chronic diffuse glomerulonephritis.

11. Nephrocalcinosis is most characteristic of: (A) Paget's disease, hyperparathyroidism, myositis ossificans; (B) tuberculosis of the kidneys, vitamin D intoxication, hyperparathyroidism; (C) hyperparathyroidism, vitamin D intoxication, renal tubular necrosis; (D) Paget's disease, tuberculosis of the kidneys, renal tubular necrosis.



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5-25

12. A patient with chronic sinusitis and associated recurrent respiratory tract infections develops intractable productive coughing with occasional small hemoptysis. The one of the following diagnostic procedures which would be most significant in establishing a diagnosis of bronchiectasis is: (A) an X-ray of the chest; (B) a bronchogram; (C) bronchoscopy; (D) examination of sputum for 3 layer formation.

13. The one of the following diseases in which examination of the bone marrow is least likely to be helpful in establishing the diagnosis is: (A) aplastic anemia; (B) leukemia; (C) Hodgkin's disease; (D) hypersplenism syndrome.

14. Of the following tests, the one which would be most diagnostic of rheumatoid arthritis is: (A) anti-streptolysin-O determination; (B) blood calcium and phosphorus determination; (C) erythrocyte sedimentation test; (D) hemolytic streptococcus agglutination test.

15. The sudden onset of pain radiating down the back of the left leg with the finding of an absent ankle jerk on the left in a previously well 40 year old patrolman suggests the diagnosis of: (A) sciatic neuritis; (B) lumbosacral sprain; (C) tabetic crisis; (D) herniated intra-vertebral disc.

16. The most common type of

surgical metabolic alkalosis due to an increase in bicarbonate ion results from: (A) vomiting; (B) diarrhea; (C) sweating; (D) high urine output.

17. The one of the following laboratory determinations which has the greatest value in establishing a diagnosis of prostatic carcinoma is: (A) elevated blood serum acid phosphatase; (B) elevated blood serum chloride; (C) elevated blood serum cholesterol; (D) elevated blood serum potassium.

18. A patient has been on gastric suction for five days. It is noted on rounds that there is moderate cyanosis, the pulse rate is 90, the blood pressure reading 86/60 mm. Hg. and there is a positive Chvostek's sign. The most likely diagnosis is: (A) perforated ulcer; (B) hypochloremic alkalosis; (C) acidosis; (D) gastrointestinal hemorrhage.

19. Coma due to acute alcoholism is associated with: (A) high blood level of alcohol; (B) Battle's sign; (C) spinal fluid oozing from the nose; (D) hemiplegia.

20. Silicosis is caused by the dust of (A) coal; (B) silicates; (C) iron; (D) silica.

21. Occupational lead poisoning in the United States is most frequently acquired by: (A) absorption through the skin; (B) ingestion; (C) inhalation; (D) implantation



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from trauma.

22. A patient develops nausea, vomiting, and diarrhea a few hours after having eaten a "contaminated" meal. The most probable etiology is: (A) acute trichiniasis; (B) acute bacillary dysentery; (C) acute botulism; (D) acute staphylococcal poisoning.

23. Increased severity of infection following cessation of the administration of ACTH or cortisone is most likely to occur when either of the drugs has been given to patients with: (A) viral diseases; (B) bacterial endocarditis; (C) staphylococcal sepsis; (D) tuberculosis.

24. Published data up to the present time indicate that one of the following has an especially effective symbiotic antibacterial action. (A) bacitracin-sulfadiazine; (B) terramycin-aureomycin; (C) penicillin-streptomycin; (D) penicillin-chloramphenicol.

25. The quantity of NaCl in the spinal fluid is characteristically reduced in: (A) meningococcus meningitis; (B) syphilitic meningitis; (C) tuberculous meningitis; (D) pneumococcal meningitis.

26. In the course of typhoid fever, a positive blood culture is most frequently obtained during the: (A) 1st week; (B) 2nd week; (C) 3rd week; (D) 4th week.

27. The association of normal urinary concentrating capacity and azotemia is consistent with the diagnosis of uremia in: (A) unilateral atrophic pyelonephritis; (B) acute malignant nephrosclerosis; (C) polycystic renal disease; (D) bilateral atrophic pyelonephritis.

28. The normal renal whole blood flow per minute as measured by the p-aminohippurate clearance is most nearly: (A) 300 cc.; (B) 600 cc.; (C) 1200 cc.; (D) 2500 cc.

29. The normal renal glomerular filtration rate per minute as measured by the insulin clearance is most nearly: (A) 75 cc.; (B) 130 cc.; (C) 600 cc.; (D) 1200 cc.

30. Numerous elliptical calcific shadows about $\frac{1}{2}$ inch in length are seen in several X-ray films of the four extremities of a patient. These are most likely due to: (A) buckshot; (B) cysticercosis; (C) *Trichinella spiralis*; (D) bismuth injections.

31. Acute amebic dysentery is most readily diagnosed by: (A) proctoscopy; (B) stool culture; (C) direct smear of stool; (D) complement fixation test.

32. Brucellosis is an infectious disease of human beings which may be acquired through ingestion or through the skin. The one of the following which cannot be a source

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Riker
LOS ANGELES

of this infection is: (A) cow; (B) goat; (C) pig; (D) horse.

33. The mechanism explaining the clinical picture observed in carbon monoxide poisoning is: (A) hemolysis of red blood cells; (B) a chemical union of the carbon monoxide with the hemoglobin of the red blood cells; (C) transformation of the carbon monoxide to carbon dioxide in the blood; (D) arrest of oxidation in the tissues by enzyme interference.

34. A 25 year old man develops a unilateral pleural effusion of clear straw colored fluid of high specific

gravity. He complains of easy fatigue; and slight weight loss, a low grade fever and a tender epididymis are the only positive clinical findings in addition to the foregoing. Of the following, the most probable diagnosis is: (A) rheumatic fever; (B) lupus erythematosus; (C) bronchogenic carcinoma with pleural metastases; (D) tuberculosis.

35. In a patient with cough, fever, signs of shifting consolidation and X-ray evidence of patchy consolidation, a cold agglutinin titer of 1:500 is observed on the tenth day of the disease. This titer may be interpreted as: (A) proof of the di-

athlete's foot

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- prompt antimycotic action
- continuing prophylaxis

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agnosis of a typical virus pneumonia; (B) compatible with but not proof of the diagnosis of a typical virus pneumonia; (C) probably unrelated to the respiratory tract disease; (D) pathognomonic evidence of primary (idiopathic) cryoglobulinemia.

36. The most usual incubation period of tetanus in patients who have not received prophylactic treatment is: (A) 2 to 3 days; (B) 5 to 10 days; (C) 25 to 28 days; (D) 85 to 90 days.

37. Of the following, the one which is not a good index of the activity of the infection in the follow-up of a patient with known long-standing pulmonary tuberculosis, previously adequately treated, is: (A) presence of post-tussive râles in the affected areas; (B) presence of Koch's bacillus in sputum; (C) erythrocyte sedimentation rate; (D) body weight determined weekly.

38. Amyl nitrite is used in the treatment of cyanide poisoning because it: (A) forms methemoglobin which competes successfully with ferricytochrome for cyanide ions; (B) improves the coronary circulation; (C) combines directly with the cyanide ions; (D) stimulates the respiratory center.

39. The characteristic electrocardiographic alteration in hyperpotasemia is: (A) elevation of the S-T

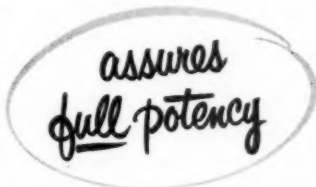


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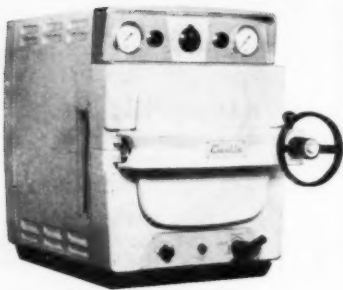
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segments; (B) heart block; (C) increase in the height of T waves; (D) a variety of ectopic rhythms.

40. The one of the following which is most useful in determining the cause of bronchial asthma in a patient is: (A) the history; (B) the skin test; (C) a sputum smear; (D) the eosinophile test.

41. Following the use of a household cleaning compound to remove spots from his uniform, a policeman becomes jaundiced. The compound which he used most probably contained: (A) lauryl sulfate; (B) ammonia; (C) benzine; (D) carbon tetrachloride.

42. A patient with inoperable bronchiectasis develops a progressive anemia in association with his chronic infection. Of the following, the plan of specific therapy of the anemia which is indicated is administration of: (A) repeated transfusions; (B) Vitamin B₁₂ and colloidal iron by mouth; (C) saccharated iron oxide intravenously; (D) liver extract and brewer's yeast by mouth.

43. A routine chest X-ray in a 40 year old man reveals a discrete, "soft," round nodule less than 1½ cm. in diameter in the periphery of the lower right lung field. The one of the following procedures which should be followed is to: (A) take no action since nodules of this type

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are insignificant; (B) institute prompt anticoagulation therapy; (C) plan prompt thoracotomy and excision of nodule if its nature cannot otherwise be positively established; (D) give a one month's trial of intensive chemotherapy with one or more antibiotics.

44. A 40 year old comatose male with cold, clammy skin, temperature 97°F., bilateral Babinski reflexes, no nuchal rigidity, and no other abnormal physical findings, has a catheterized urine which shows albuminura +, glucose ++ no acetone or diacetic, rare red blood cell and white blood cell per high power field. Serum urea nitrogen is 23 mg./100 cc. Of the following, the best diagnosis is: (A) diabetic acidosis; (B) insulin shock; (C) meningitis; (D) uremia.

MEDIQUIZ ANSWERS

1 (B), 2 (D), 3 (A), 4 (A), 5 (C), 6 (B), 7 (A), 8 (D), 9 (D), 10 (A), 11 (C), 12 (B), 13 (C), 14 (D), 15 (D), 16 (A), 17 (A), 18 (B), 19 (A), 20 (D), 21 (C), 22 (D), 23 (D), 24 (C), 25 (C), 26 (A), 27 (B), 28 (C), 29 (B), 30 (B), 31 (C), 32 (D), 33 (B), 34 (D), 35 (B), 36 (B), 37 (A), 38 (A), 39 (C), 40 (A), 41 (D), 42 (A), 43 (C), 44 (B).



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What's the Doctor's Name?

By James F. Gallagher

He was born October 3, 1854, and died July 4, 1920. His mother was the daughter of a former governor of Alabama and his father, though a Pennsylvanian, became a brigadier general and the Chief of Ordnance for the Confederacy. As a boy he witnessed the fall of Fort Sumter and was present at the funeral of Stonewall Jackson.

He took his A.B. from the University of the South in 1875 and received his M.D. from Bellevue Medical College, New York City, in 1879. He did his internship at Bellevue Hospital and even while a student, to get outside experience, he became a member of the home staff of the New York Insane Asylum at Blackwell's Island. In 1880 he entered the Army's Medical Department.

While treating Miss Marie Doughty for yellow fever he contracted the disease; he also fell in love. After they were married she said: "It would not be true to say that Yellow

Jack was the best man at our wedding, but it would be perfectly true to say that, in a sense, he was an usher."

In 1898 he was sent to Havana, Cuba, as sanitation director. Influenced by Dr. Carlos J. Finlay and Walter Reed, he began a control of the yellow fever mosquito, and within a few months permanently rid the city of the grip which yellow fever had upon it for 150 years. He was next given charge of sanitation in the Panama Canal Zone. A newspaper man wrote of his work there: "He has inspired fifty thousand laborers to live cheerfully for several years in a fever swamp, simply because he was with them."

He was elected president of the American Medical Association in 1908, and was also president of the America Society of Tropical Medicine. He worked with the International Health Board in an effort to eradicate yellow fever from South America and western Africa. During the American participation in World War I, he headed the Army Medical Service, being made Surgeon General of the Army with the rank of brigadier general, April 6, 1914. On March 4, 1915, in recognition of his achievements in sanitation, he was advanced to major general by special act of Congress.

A recent biography of him by John M. Gibson is titled *Physician to the World*.

Can you name this doctor without turning to page 170?

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WHAT'S THE DOCTOR'S NAME?

(from page 162)

WILLIAM CRAWFORD GORGAS

VIEWBOX DIAGNOSIS

(from page 17)

ILEUS

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RESIDENT RELAXER

(puzzle on page 13)

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